Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 2008 chae ose ordor /Medical 4c. County of Death 4b. City, Town, or Location of Death Facility Name (If not institution, give Examiner imor Itimore 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Age (In yrs. 6. Sex 5. Social Security Number Months Days **Funeral** Hours 1⊠M 2□F 52 219-68-4696 Feb. 03,1956 Houston, Director Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits 10b. County 10a. State 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 1 X Yes 2 No Rowie Prince George's Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with t. Department of Health and Mental Hygiene. Important: If iten 27 is marked other than "nature!" — any injury or other traumatic events. USA 20716 15422 N. Platte Ct Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No U.S. ARMY 11 Marital Status Black, White, etc. 1 ⊠ Never Married 2 ☐ Married 1 ☐ Yes 2 🖾 No Specify: White If  $\overline{Y}$ es, Give Year or Dates: 1972 - 19743 ☐ Widowed 4 ☐ Divorced ģ Completed 16b, Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) n/a n/a 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jean W. Hesen Michael Donald Gordon ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11501 Crows Nest Road, Clarksville, MD 21029 Gerard Gordon / Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ⊠ Burial 2 ☐ Cremation 3 □Removal from State 10/04/2008 Washington, DC Mt. Olivet Cemetery 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Hyattsville, MD 20781 Gasch's Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Circhosis Smonths **Physician** /Medical Due to (or as a consequence of) 5 months Examiner Hepatitis Sequentially list conditions, if any, leading to immediate cause. Enter ordering Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical the. as attending p for use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 □Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy page 1∐ Yes 2 No certificate or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical director Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 🔲 Yes 2 10 P After this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

IVA State Registrar

31. Date filed (Month, Day, Year, OCT 0 6 2008

29b. Signature and title of certifier Veronica Z.

Veronica



Medical Resident

Linares, MD

30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

08

Baltimore, MD

08-07374 UNK UNK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2008 33502

IN ONK		For State	of Maryland / D	Certificate	of Death			Reg.	No.	
Physician/	Reg	gistrar Decedent's Name (First, Middle,Las	st)				2	2. Date of Death Month Da	av Year	3. Time of Death 2243 hrs
edical Examiner		000	Guapo				- 1	September 2	7, 2008	
,	4a	Facility Name (if not institution, given by E/B Route 450 at Carter A			4b. City, Tov Lanhan		on of Death		4c. County of Prince Ge	eorge's
Funeral Director	5.	Social Security Number 6. S	ex 7. Age (In 2.2)	yrs. last birthday) 2	If Under Months		Jnder 24Hrs. ours Min.	8. Date of Birth(I		9. Birthplace (State or Foreign Mexico
AD 21215-0036  2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show any smatte event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	10	De. Street and Number  5 2 0 5 Dartmoor Co  1. Marital Status  X Never Married 2 Marrie	George's	No	10f. Zip C	06 t of Hispanic Cuban, Mex	Origin? (Spican, Puerto l	ecify Yes or No- Rican, etc.)	White	- American Indian, Black,
21215-0036  uld be filed within 72 hours after Mandel Hygiens after marked other than "natural", e event, the Medical Examiner to Be Completed by 1		15. Decedent's Education (Specify Elementary/Secondary (0-12) 6th	only highest grade completed College (1-4 or 5+)	ted) 16a. Dece durin	dent's Usual O g most of work les Per	eccupation (Ging life, DO I	Give kind of w NOT use retir	rork done 1 ed)	6b. Kind of Bus	siness/Industry t Factory
Hygined The	ן (	7. Father's Name (First, Middle, Las	51)					Zurita		
Mental Fill be		Unknown 9a. Informant's Name/Relationship	(Type Print )	19b. Ma	iling Address				er, City or Tow	n, State, Zip Code)
MD 2 nd 2 shoul lith and M m 27 is m aumatic	- 1	armela Zurita	(Mother)					ham, Mar	yland	20706
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'injury or other traumatic event, the Medical To Be Complet	2	0a. Method of Disposition  X Burial 2 Cremation	Removal from State	20b. Place of Di	position (Nam r other place)	e of cemeter	y,	Date 09 / 2008	20c. Location -	City or Town, State
Itin pit. P. artmei		Donation 5 Other Special Signature of Funeral Service Lic			22. Name and	Address of F	acility n Fune	ral Home	. Inc.	on, DC 20010
Dep Permining	ı	Manda Co	Bacon, Co							
Physician / Medical raminer	1	23a. Part I. Enter the disease, or confailure. List only one cause on Immediate Cause (Final disease or condition resulting in death)	nplications that caused the each line. a. Head Injuries  Due to (or as a consequ		ter the mode o	f dying, such	as cardiac c	r respiratory arres	st, snock, or ne	Between Onset and Death
ceuted and transit	Examiner	Sequentially list conditions, fany, leading to immediate cause. Enter Underlying Cause (Disease or injury shall hilfated events resulting in death) Last	Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)							
0, the exect sician an burial - tr	Medical	UNPENDED	AMENDED							
0 44	ysician/	IF FEMALE: 3b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	J Gillarouni	ne of death 5	Fetal death Other (Spec	cify)	Ectopic pregn		23d. Date of Month	of delivery Day Year  tribute to the cause of death?
O. I of the d by the etache		Part II. Other significant condition	ns contributing to death b	out not resulting in	the underlying	cause giver	n in Part I.			Probably 4 Unknown
Division of Vital Records, P.C. To the Hospital or Attending Physician: The law requires that within 24 hours after death, the this sertificate has been signed completely filled in by the funeral director, page 2 should be determined.	Completed by							24a. Was a autop: perfor	an 24b. sy med?	Were autopsy findings available prior to completion of cause of death?  1  Yes 2 No
Re The ificate	ខ្ញុំ	25. Was case referred to medical				26.Place of	Death (Check			
ital sician irecto	mĭ	examiner?	Hospital: 1 Inpatient	2 ER/Outp	atient 3 D	OOA Oth	ner Nurs	ing Home 5	Residence 6	✔ Other: Scene
on of V nding Phys th. After thi	ilon: To	1 ✓ Yes 2 No  27. Manner of Death 1 Natural 5 Pendin			, . ,	28c. Injury a	t Work? 2 ✔ No	28d. Describe t Pedestrian s	struck by au	uto
Division ital or Attending after death ral Director:	Certification:	2 V Accident Investion 3 Suicide 6 Could determ 4 Homicide	not be 28e. Place of Injurined (Specify) Majo	or Road / High	iway			or Town, S E/B Route 45	State) 0 at Carter A	ber or Rural Route Number, City veneue, Lanham, MD
To the Hospita within 24 hours To the Funeral completely fille	Medical C	29a, Certifier	sician: To the best of my iner: On the basis of examinand manner stated.	knowledge, death ination and/or inve	estigation, in m	y opinion, de	eath occurred	nd due to the caus I at the time, date	and place, and	1 due to the cause(s)
F. 2 E. 8	울	29b. Signature and title of certifier	n /1/ -		29	lc. License n			1	gned (Month, Day, Year) er 28, 2008
		Veryonte	The Youll	_		O.C.M.	E.		Septemb	
R6		30. Name and address of person wargarita Korell MD.	Assistant Medical E	xaminer 1	11 Penn St	reet, Balt	imore, MI	21201		
Sta Registr	ate	31. Date filed (Month, Day Year)	32. Registrar	s Signature	2					

Certificate of Death

and manner stated.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4c. County of Death Calvert 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)
Wash. D.C. 1964 10d. Inside City Limits 1 ☐ Yes 2 ☑ No 10g. Citizen of What Country? 14. Race - American Indian Black White etc. White Specify. 16b. Kind of Business/Industry Public Utility Holcomb 20c. Location - City or Town, State Port Republic, MD Lee Funeral Home Calvert, PA Owings. MD Approximate Interval Between Onset and Death 23d. Date of delivery Month Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 2 No Other: 4 Nursing Home 5 Persidence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) lusby Md 20657

Reg. No.

Day

2008

3. Time of Death

8:15 A

State Registrar (Check only one)

296. Signature and title of certifier

filed (Month, Day, Yea 3 2008

NATR NO

within 2

town Square Dr

000111

29c. License number

7588

			For State		State of	Marylan	id / Dep	artmen e <i>rtificat</i>	t of H	lealth a	and M	lental Hy		118	33504
PI	hysicia		Registrar  1. Decedent's Name		nst) Marie Ta	te Cre		eruncai	e or i	Dealii		2. Date of Do	Day	Year	
	/Medic	_	4a. Facility Name (If I				- CII	4b Cibi	Tour	r Location	of Dooth	UCTODE	r 1, 2	unty of Dea	1:05 P. M
E	xamin	er		01d Yorl		001)		40. City,	Boy		OI Death				Georges
			5. Social Security Nu			. Age (In yrs.	last hirthda	) If Under	•	If Under	24 Hrs.	8. Date of Bi	eth		
	neral ector		260-58-1	561	1□M 2 <b>X</b> F	69		Months		Hours	Min.	(Month, D.	20,193	9 G	rthplace (State or Foreigr country) Corgia
pu	3	-	Usual Residence of D	10b. County		10c Cit	y, Town or I	ocation		,					10d. Inside City Limits
Maryla	fied at	tor	Maryland		Georges		Lanha								1 X Yes 2 □ No
the	28	Directo	10e. Street and Numl	ber				10f. Zip	Code				10g. Citizen	of What C	ountry?
h with	238 O	al D	9219 A1	Lcona St	reet				2070	06			Unite	d Sta	ates
be filed within 72 hours atter death with the Maryland the Hygienes.	item 2/1s marked other than "natural", or lems 23s or 28s-f show other treumatic event, the Modical Expirier must be notified at	by Funeral	11. Marital Status 1 □ Never Married 3 🛣 Widowed 4	_	12. Was Deced Armed Forc 1 Tes 2 If Yes, Give Year or Dat	es? No	.S. 13	Was Deced If Yes, spe-		ispanic Ori an, Mexicar Specify:		ecify Yes or N Rican, etc.)		Race - Am Black, Whi acify: <b>B</b> ]	
n 72 ha	adical	Completed		15. Decedent's E y only highest gi			(Giv	edent's Usua re kind of wo DO NOT u	rk done o	during mos	st of work	ing	16b. Kind		
d withii giene.	the M	omo	Elementary/Second	dary (0-12)	8+ years					•	of N	lursing		ra on pital	iversity
2 should be filed within and Mental Hygiene.	atic event	To Be C	17. Father's Name (F								er's Name <b>amie</b>	e (First, Middle Fort		name)	
and 2 sho	z7 is m er treum	1	19a. Informant's Nan Reisa Ga			hter)						al Route Numb Bowie,			
Pages 1 annual He	nt: If item iry or othe		20a. Method of Dispo	osition Cremation 3 [	Removal from St	20b. F	Place of Disp cemetery, cr	oosition (Nar ematory or d	me of other plac	e) C	ct.6	,2008	20c. Locati	on - City o	r Town, State  Maryland
permit. Depertin	important: If its any injury or of once.		21. signature of Fund	eral Service Lig	108	Joel	/	R. N.	nd Addres	ss of Facili	Compa	any Mor	tician	s, Ir	
	\$		23a. Part1. Enter the shock, or heart	e disease, or con failure. List only	plications that can one cause on each	used the deat ch line.	h. Do not e								Approximate Interval Between
	ician dical niner		Immediate Cause (F disease or condition resulting in death)			1aSla ras a conseq		ung	Ca	nce	V				Onset and Death
	al-transit	xamlner	Sequentially list conditions, leading to immicause. Enter Underhouse (Disease or inhat initiated events resulting in death) La	neclate ying njury	c.	r as a conseq									

anding physicien an use as the burial-tr signed by the at d be detached for

by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 Dectopic pregnancy 5 Other (specify)
Completed by PI	Part II. Other significant conditions Diabczes 1	contributing to death but not resulting in	the underlying cause given in Part I.
To Be Con	25. Was case referred to medical examiner? 1 ☐ Yes 2 🏋 No	Hospital: 1   Inpatient 2   ER/Outp	26. Place

Ex æ Certification Medical

or Attending Physician: The law requires that the death certificate be exer To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certific completely filled in by the funeral director.

Division of Vital Records, P.O. Box 68760,

State Registrar

24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death Check only one Daughter's Cther: 4 ☐ Nursing Home 5 ☐ Residence 6 X Other (Specify) Home Hospital: 1 ☐ Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 XNatural Injury 1 Yes 2 No 2 Accident 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

1 Certifying Physician: To the best of my knowledge, seath occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical Examiner: On the basis of exa 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

MD 42719

Due to (or as a consequence of):

, 2008 October 0

23d. Date of delivery

Day

2 No 3 Probably 4 Unknown

Year

Month

23e. Did tobacco use contribute to the cause of death?

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dawne M. Carroll, M.D.; 7401 Forbes Blvd.; Suite B-2; Lanham, Maryland 20706

31. Date filed (Month, Day, Year) OCT 0 7 2008

10f. Zip Code

1 ☐ Yes 2 🛣 No

20874

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Specify.

3. Time of Death

 Birthplace (State or Foreign Country) Philippines

10g, Citizen of What Country?

United States

14. Race - American Indian.

filipino

Black, White, etc

10d. Inside City Limits

1 ☐ Yes 2X No

7:15pm<sup>M</sup>

1 - For State	e strar
---------------	------------

10a. State

Maryland

11. Marital Status

10e. Street and Number

Directo

Funeral

Usual Residence of Decedent

1 ☐ Never Married 2X Married

10b. County

Montgomery

13114 Briarcliff Terrace #406

State of Maryland / Department of Health and Mental Hygiene Cartificate of Death

10c. City, Town or Location

Germantown

	Registrar		C	eruncai	e or t	Jeani		Re	g. No.	
Dhusisian	1. Decedent's Name (First, Midd	lle, Last)						2. Date of Death Month	Dav	Ye <i>a</i> r
Physician /Medical	Edmunda Ahad (	San Gabrie	1					October	4, 200	
Examiner	4a. Facility Name (If not institution	on, give street and nu	umber)	4b. City,	Town, or	Location	of Death		4c. Count	y of Death
	Shady Grove Ad	lventist H	lospital	Roc	kvil	.le			Mont	gomery
Funeral	5. Social Security Number	6. Sex	7. Age (In yrs. last birtho	(y) If Under		If Under		8. Date of Birth (Month, Day,	Voarl	9. Birthpla
Director	124-46-4459	1 🖾 M 2 🗆 F	76 Yrs	·	D <i>a</i> ys	Hours	Min.	Aug. 8.	1932	Phili

12. Was Decedent Ever in U.S. Armed Forces?

filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examination until be notified at

Baltimore, Maryland 21215-0036

**Physician** /Medical Examiner

Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar attending physician for use as the buria signed I director, page 2 should completely filled in by the funeral within 24 hours after deat To the Funeral Director:

Division of Vital Records, P.O. Box 68760,

1 Tes 2 No If Yes, Give Year or Dates: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Architect Architecture 18. Mother's Name (First, Middle, Maiden Surname) Be ( 17. Father's Name (First, Middle, Last) Gavino San Gabriel Expectacion Abad 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13114 Briarcliff Terrace #406, Germantowa, MD 20874 Magnet San Gabriel (Spouse) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 

Burial 2 □ Cremation 3 □ Removal from State 10/8/08 Germantown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Souls Cemetery 22 Name and Address of Facility DeVol Funeral Home IO East Deer Park Drive 21. Signature of Function Service Licenses Gaithersburg, Maryland 20877 Approximate
Interval Between
Onset and Death 1. Enter I r cur lications that caus List only one cause on each of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, line. hock, or h l mediate Came (Final d ease or dition re ullimin death) Due t (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24a. Was an autopsy performed? 1 □ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D42518 Dete signed (Month, Day, Year)

D42518 OCTOBERS, 2008

Providence, Roeburus - wess 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1119 Rowerero

State Registrar CHAISLANI

07

Year)

31. Date filed (Month, Day,

OCT

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08-07487 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2008 33506 Russell Paul Gushen State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 3. Time of Death Month Day October 3, 2008 Medical Examiner 1222 hrs Russell Paul Gushen 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Silver Spring 904 Kerwin Road Montgomery 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or oreign Months Days Hours Director Country) Maryland 214-76-6244 1 X M 2 54 6. 1954 Usual Residence of Decedent 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits Yes 2 X No 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryland neut of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho tem 27 is marked other than "natural", or items 23s or 28s-f sho traumatic event, the Medical Examiner must he notified at once. Maryland Montgomery Silver Spring Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 904 Kerwin Road 20901 United States 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, Funer If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces 1 X Never Married 2 Mamie 2 X No Yes If Yes. Give Year Widowed Δ Divorced Yes 2 X No specify: Specify: White à 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 12 Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward Joseph Gushen, Sr. Louise Eileen Cadagan ٩ 19a. Informant's Name/Relationship (Type, Print) Sb. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8109 Plum Creek Drive Gaithersburg, MD 20882 Sandra Grozbean, Sister Gaithersburg, M 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 20c. Location - City or Town, State Baltimore, Burial 2 X Cremation 3 Removal from State crematory or other place) OCT. 6, mportant: 2008 Atlantic Crematory Donation 5 Other Specify Glen Burnie, Maryland 5 22. Name and Address of Facility
Thibadeau Mortuary Service, P.A.
933 Gist Ave., LL, Silver Spring, 21. Signature of Funeral Service Licensee Burn migu M01508 MD 20910 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line. Between Onset and /Medical a. Atherosclerotic Cardiovascular Disease Death -xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician and or use as the burial - transit Physician/Medical UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, IF FEMALE: 23d. Date of delivery 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Day Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? á Yes 2 No 3 Probably 4 ✔ Unknown Chronic Alcohol Abuse Completed Atter this certificate has been s funeral director, page 2 should b 24a, Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? Yes 2 1 🗸 Yes To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital Inpatient Nursing Home 5 Residence 6 Other: Scene ٩ 1 V Yes 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? Certification: 1 V Natural Pending Yes 2 No To the Funeral Director: filled in by the Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) (Specify) Homicide 29a. Certifier 1 completely Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number O.C.M.E. October 4, 2008

State Registrar Jack Titus MD.

31. Date filed (Month

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

0 7 2008

Deputy Chief Medical Examiner

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month OCTOBER 5, PAULINE GREEN 5:24P M MARGARET 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK
Index 1 Year If Under 24 Hrs. FREDERICK 5. Social Security Number 8. Date of Birth (Month, Day, Year) March 28, 1916 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 1 □ M 2 🗷 F 214-10-1154 92 Director Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, if Medical Evanimatic must be notified at once. 10b. County 10c. City, Town or Location 10a State 10d. Inside City Limits Director Maryland Maryland Frederick Frederick 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 306 Sherman Avenue 21701 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates: White 1 ☐ Yes 2 No Specify: þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Paul Young Vernie Stockman ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eva Wright / Sister 110-1D Idlewild Road, Bel Air, Maryland 21014 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State October 1 

Burial 2 □ Cremation 3 □ Removal from State Mount Olivet Cemetery 10, 2008 4 ☐ Donation 5 ☐ Other (Specify) Frederick, Maryland 21. Signature of Funeral S 22. Name and Address of Facility Keeney & Basford P.A. Funeral Home 106 East Church Street, Frederick, Maryland 21701 M01433 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final STROKE Physician Week disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injur) that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-trar Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗀 Ectopic pregnancy in the past 12 months?
1 □ Yes 2 ☒ No Month Year Day 5 Other (specify) 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has be irector, page 2 s autopsy performed? 1 ☐ Yes 2 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier npletely (Check only one)

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, After n 24 hours after death. • Funeral Director: A bletely filled in by the fu within 2.

To the I complet

Baltimore, Maryland 21215-0036

State Registrar 801 TOLL

Frederick

29d. Date signed (Month, Day, Year)

10-7-08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Couldi

29c. License number

D43091

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** OCTOBER 2008 Year DORIS GROSSNICKLE 12:12 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 ☐ M 2 🔀 F Yrs. 212-78-8472 89 Director MD Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show Director 1 □Yes 217 No Middletown MD Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 7908 Myersville Rd. 21769 or items 23a USA Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√ No Specify. ģ Specify: White 3 XWidowed 4 ☐ Divorced "naturaf" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 8 own home homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Russell P. Wiles Sr. ပ္ Letha Alice Grossnickel 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau once. Monroe Grossnickle (Son) 211 Stauffer Ct., Walkersville, MD 21793 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition B Removal from State 1 X Burnal 2 ☐ Cremation Grossnickle Cemetery 4 ☐ Onation 5 ☐ Other (Specify) Myersville, MD Ture Donald B. Thompson Funeral Home 18, Middletown, MD 21769 Enter the observe, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician mtracrania massive disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Exami physician and s the burial-trans resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) certificate has been signed by the rector, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy perform 2 **A** No 1 ☐ Yes 2 ☐ No 1 □ Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 124 hours after death, e Funeral Director: Aft eletely filled in by the fun 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely (Check only within 2. and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MDD 35106 10/2/2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Myung Hee Nam 400 W. 7th St., Frederick, MD 21701

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

UCI 07

32. Registrar's Signature

			For State Registrar	State of	Marylan	-	artment of H		and Me	, ,	iene	308	335	09
Œ.	Physici /Medic		1. Decedent's Name <i>(First, Middle, L</i> Stephen	ast) Kee	fer	Gey	ver, Jr.			Date of Dea Month	Day	Year 2008	3. Time of De 3:50A	eath M
)	Examin		4a. Facility Name (If not institution, g	al			4b. City, Town, or Cumberla	nd	of Death	•	4c. Cou	inty of Death		
	Funeral Director		5. Social Security Number 6. 216–20–4283  Usual Residence of Decedent	Sex 1∏XM 2□F	7. Age (In yrs. I 81	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	Date of Birth (Month, Day)	, Year)		lace (State or F try)	oreign
	e Maryland a-f show liffied at	ctor	10a. State 10b. County WV More	an	10c. City	Great	cation Cacapon					11	0d. Inside City	
	ath with the 23a or 28 ust be no	ral Director	10e. Street and Number 83 Bears Lope	Lane				25422			-	of What Coun USA	try?	
20	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 X Married 3 □ Widowed 4 □ Divorced	Armed For	2 □ No		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🛣 No	ispanic Oric an, Mexican Specify:	gin? (Specif i, Puerto Ric	y Yes or No- can, etc.)	'	Race - America Black, White, of ecify:		
70-617	thin 72 hou e. <b>an "natura</b> Medical E	Completed	15. Decedent's (Specify only highest g	 Education		16a. Deced (Give life. L	dent's Usual Occup kind of work done o DO NOT use retired	ation during most f)	of working		16b. Kind o	of Business/Inc	lustry	
7 7	illed wil Hygien other th	Be Con	Elementary/Secondary (0-12) 12 17. Father's Name ( <i>First, Middle, La.</i>	2	,	I	Inspector	18. Mothe	r's Name (F	First, Middle, I		vator		
Jan	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, th∗ M∈	To B	Stephen K	eefer	Ge	yer, S			sie	2-1-11-11-1	. 07. — T	Schmi		
, Ma	and 2 s ealth an n 27 Is r ner traus		Stephen M. Geyer			P.O.	Box 360					wn, State, Zip 25422	Code)	
	Pages 1 lent of H nt: If iter ry or oth		20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		State	emetery, crer	sition <i>(Name of</i> natory or other plac nd Cremat		Date 0 / 0 1 / 3			on - City or To erland,		
Dall	permit. Pages 1 and 2 Department of Health s Important: If item 27 li any Injury or other tra		21. Signature of Funeral Service Lo		mob		2. Name and Address 404 Deca	ss of Facility	y Adai	ms Fam:	ily Fu	uneral		?.A.
	Physician		23a. Part1. Firm r the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	y one cause on ea	aused the death ach line.			g, such as	cardiac or r	espiratory arr	est,		Approximate Interval Betwe Onset and Dec	en ath
	/Medical Examiner	<u>.</u>	Sequentially list conditions	b. DIF	or as a consequence as a consequence of the consequ	REN	AL DIS	EASE	5,				Tyrs	<u>-</u>
<u> </u>	icate be executed physician and the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	or as a consequ									
0000	rtificate be ng physicia as the bu	Medical	IF FEMALE:	d										
0.00	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown		rth 2  Fetal ant at time of de	death 3	Ectopic pregnancy Other (specify)				23d.	Date of delive Month	ry Day Yea	ar
, CD .	w requires that the d been signed by the should be detached	ρ	Part II. Other significant conditions	contributing to de	ath but not resu	Iting in the ur	nderlying cause give	en in Part I.					e cause of dea	
	hystcian: The law re his certificate has bee I director, page 2 sho	Completed	——————————————————————————————————————							24a. Was a autops perform	sy	prior to cor death?	osy findings ava npletion of caus 2□ No	ailable se of
A ILC	yslcian; s certific director,	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No	Hospital: 1	patient 2∐I	ER/Outpatien	t 3DDOA Othe	ar.		Check only on	e)			
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifice completely filled in by the funeral director.	-1	27. Manner of Death  1 Natural 5 Pending 2 Accident investigati	28a. Date of (Month		28b. Time of Injury	28c. Injur Work		280	d. Describe ho		Other (Specify curred	<i>'</i> )	
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Could not determine	d 28e. Place buildin	g, etc. (Specify	)	eet, factory, office			City or Towr	n, State)		Route Numbe	τ,
	he Hosp in 24 hou he Fune pletely fi	Medical	29a. Certifier 1 ☐ Certifying F (Check only one) 2 ☐ Medical Ex-	Physician: To the aminer: On the baland maph	sis of examinat	vledge, death ion and/or in	n occurred at the tir vestigation, in my o	ne, date an pinion, dea	d place, and th occurred	d due to the c at the time, d	ause(s) and late and pla	d manner as st ce, and due to	ated. the cause(s)	
	~ i	Σ	29b. Signature and title of certifie	1/			29c. License		( )			gned (Month, I	-	
,	5/1VA		30. Name and address of person wh				Print)		6		eptemi	ber Z	7 2008	
	N & Sta		31. Date files (Porth Pay 2011)	M.D. 32. Re	124 Signat	ETON ure	DP. (	MHE	SERLI	MOUA	MD	2150	2	
	Registr	ar	OLI 0 0 2000	- Cock	U ST	Good								

08-07457 Raymond Gardne	er, J	Please Type or Print in Black Indelible Ink. Ensure All Court State of Maryland / Department of Health and Mer		gible.	- 0071/
Dhusisis		1- For State Registrar 1. Decedent's Name (First, Middle,Last)		eg. No. 200	3 3 3 5   ( 3. Time of Death
Physicia Medical Examir	er	RAYMOND GARDNER JR.	Month October 2	Day Year , 2008	0814 hrs
L M.		4a. Facility Name (if not institution, give street and number) 4165 Southern Avenue 4b. City, Town, or Location Capitol Heights	of Death	4c. County of Death Prince George	1
Funeral Director		Months Days Hour	ler 24Hrs. 8. Date of Bi	9, 1958 Foreig	thplace (State or in WASHINGTON
	ŀ	Usual Residence of Decedent	AUNIE	J, 1330 W	untry) DC
nd show any	_	DC 10b. County 10c. City, Town or Location WASHINGTON			10d. Inside City Limits 1 XYes 2 No
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number         10f. Zip Code           5351 ASTOR PL., S.E.         20019	1	Og. Citizen of What Coul UNITED STA	*
with the ms 23a c		11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Or		)- 14. Race - Amer	can Indian, Black,
her death	/ Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexical 1 Yes 2 No No Specify Specify Cuban, Mexical 1 Yes 2 No Specify Specify Cuban, Mexical 1 Yes 2 No Specify		White, etc.  Specify: BLA	CK
hours at	ted by	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give	kind of work done	16b. Kind of Business/	
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21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medic	Be Co		er's Name (First, Middle, RIE GARDNE	,	
MD 21; d 2 should b th and Men n 27 is mar numatic eve	]ع	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Nu	mber or Rural Route Nu	mber, City or Town, State	
re, M s 1 and 2 f Health If item 2 er traum		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date	20c. Location - City or	Town, State
Baltimore, permit, Pages I at Department of Hee Important: If ite		1 XBurial 2 Cremation 3 Removal from State WASHINGTON NAT. CEM. 4 Donation 5 Other Specify: 21. Songure of Funeral Service Liceusee 22. Name and Address of Facility	10/10/08		MD —
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Physician /Medical		23a. Part I. Enter the disease, or complications that gaused the death Do not enter the mode of dying, such as failure. List only one cause on each line.  Immediate Cause (Final Isease a. Acquired immunodeficiency sundro			Approximate Interval Between Onset and Death
Examiner		or condition resulting in death)  Due to (or as a consequence of): complications			
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Box e death or the attenued for us	Physici	1 Yes 2 No 9 Unknown 9 Unknown 9 Unknown Checkfy)			
P.O.	≦	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in F  Cancer		obacco use contribute to	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Finneral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Completed		24a. Was	psy prior to	utopsy findings available completion of cause of
Vital Reconsiders: The la		25. Was case referred to medical 26.Place of Death		ormed? death? 2 ✓ No 1 Y	es 2 No
of Vital ng Physician: After this certi	To Be	examiner?  1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other:4	Nursing Home 5	Residence 6 V Othe	r: Scene
on of Vinding Physiath.		27. Manner of Death  1 Natural 5 Pending  28a. Date of Injury (Month, Day,Year)  28b. Time of Injury 28b. Time of Injury 1 Yes 2	_ 1	how injury occurred	
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Division To the Hospital or Attend within 24 hours after death. To the Fineral Director: completely filled in by the 1	O	4 Homicide determined (Specify)  29a. Certifier (Check only)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and p	lace, and due to the cau	se(s) and manner as stat	ed.
To the Hos within 24 h To the Fur completely	edic	one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death of and manner stated.  29b. Signature and title of certifier  29c. License number		and place, and due to the	
- En		O.C.M.E.		October 3, 2008	) = = y, , = == /
4 6		30. Name and address of person who completed cause of death (Item 23s)  Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore,	MD 21201		
Sta	ate	31. Date filed (Month, 2007)ear)  32. Registrar's Signature			
Regist	GII				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 2008 1230 Paul Franklin Hamm October 0 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Ceci1 59 Edgewood Hills Road North East If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday, 5. Social Security Number 6. Sex **Funeral** 1 🕅 M 2□ F Director 199-32-5192 SEPT 13, 1941 Tennessee 67 filed within 72 hours after death with the Maryland Hygiene. Mer than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notifled at 1 ☐ Yes 2 🕅 No Director North East Maryland Ceci1 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 59 Edgewood Hills Road 21901 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1964- If Yes, Give Year or Dates: Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Maryland State Trooper Law Enforcement other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be d 2 should be f th and Mental H Ith and Ments 27 is marked traumatic e Joseph Hamm Lexie Fay Willen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2: Department of Health at Important: If Item 27 is any Injury or other trau Carol I. Hamm/Wife 59 Edgewood Hills Road, North East, MD 21901 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gilpin Manor 20c. Location - City or Town, State 20a. Method of Disposition October 17, Pages 1 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Elkton, MD Memorial Park 22. Name and Address of Facility
Hicks Home for Funerals, P.A.
103 W. Stockton Street, Elkton, MD 21. Signature of Funeral Service Licensee 21921 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of) MINUTES /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and the burial-transit Due to (or as a consequence of) Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a Id be detached for P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, \$ 1 Tes 2 No 3 Probably 4 Unknown DIALETES Mellitus Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Hypertension To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has I completely filled in by the funeral director, page 2 s autopsy performed? (es 2 No 1∐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) 1 Yes 25 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 2 ☐ Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 🖳 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

E. LATTIN.

31. Date filed (Month, Day, Year) 0CT 2 1 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

G. M

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32. Registrar's Signature

			For Stata Registrar		Marylan		artmen rtificat			and M		Rag. N	40	08	33512
ı	Physici /Medic		1. Decedent's Name (First, Middle, Las GRACE LOUISE HAR								2. Date of D		ау б,	2008	3. Time of Death 6:20 M
}	Examir		4a. Facility Name (If not institution, give	street and num	ber)		4b. City,	Town, or	Location of	of Death		4	c. Coun	ty of Death	
			2715 Meredith Ro					ite I					Bal	Ltimor	
	Funeral Director		5. Social Security Number 6. Social Security Number 216-96-0201 1  Usual Residence of Decedent	9X □ M 2 <del>X X</del> F	7. Age (In yrs. 87		Months	1 Year Days	If Under: Hours	Min.	8. Date of Bi (Month, D AUG . 2	ay, Year	921	9. Birthp Coun Mar	place (State or Foreign htty) yland
	Maryland show	or	10a. State 10b. County MD Baltim	ore		y, Town or Lo				, ,				1	0d. Inside City Limits 1 Yes 2 No
	with the I	Direct	10e. Street and Number 2715 Meredith Ro	ad			10f. Zip	Code 1161				_	itizen o USA	f What Cour	ntry?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23e or 28e-1 show may injury or other traumatic event, if a Madical Examinal be routiled at ODGs.	by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Dece Armed For 1  Yes If Yes, Give Year or Da	ces? 2 <del>∏</del> No •			dent of H	ispanic Ori n, Mexican Specify:	gin? (Spo i, Puerto	ecify Yes or N Rican, etc.)		14. R	ace - Americ ack, White, sity: Wh	
21215-0036	hin 72 hou e. an "natura Modical E	Completed b	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	lucation	17	16a. Dece (Give life.	dent's Usu kind of wo DO NOT u	al Occupa rk done d se retired	ation during most	t of work	ing	16b. I	Kind of	Business/Ind	dustry
2	ed wit ygiene yar the	Con	none			nor	ne								
and	be fill stal H st off	Be	17. Father's Name (First, Middle, Last)								First, Middle				
Maryland	d Mer d Mer marke	P	Unknown	Type Print)		19h Maili	ng Address	(Street			11a Mar al Route Numb				Code
<u>⊠</u>	ith an		19a. Informant's Name/Relationship (Michelle M. Delo	zier-	nnMar Rep.		Box (				d Line,			71, 31218, 210 21105	(000)
Baltimore,	Pages 1 all and of Heal and it: If itam y or othe		20a. Method of Disposition 1		20b. F	Place of Disponentery, creametery, creametery	osition (Name	ne of other plac			2008	1	ocation	Rock,	
Balti	permit. E Departm Importar any inju		21. Signature of Funeral Service Licentary	<u> </u>	#CC026	2:	2. Name ar	ad Addres	s of Facilit	у	me, Inc			Main S n Rock	
8760, 7	Physician Medical Examiner  but a principle of the princi	Ilcal Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	or as a conseq Qu	utz k quence of):	alvu Zespi D	leve	in life	ever F	alu	re			Interval Between Onset and Death
.O. Box 6	death certif e attending id for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		rth 2 ☐ Feta unt at time of d	al death 3	⊒Ectopic p							Date of delive	ery Day Year
ds, P	Se us	by	Part II. Dther significant conditions of	ontributing to de	ath but not res	sulting in the u	ınderiying d	ause give	en in Part I.				use co		ne cause of death?
Vital Records,	The law ate has b page 2 sl	Completed										s an opsy formed? 2/2 N		prior to con death?	psy findings available mpletion of cause of 2 No
Zii.	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Oth			(Check only				
o	ding Phys h. After this funeral dir	lon: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending	28a. Date o		28b. Time of Injury		28c. Injun Worl	4   140		me 5 Res 28d. Describe				y)
Division	or Attan fter deal Diractor: in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place	of Injury - At h g, etc. (Specia	ome, farm, st fy)					28f. Location City or To			mber or Rura	I Route Number,
	ne Hospital n 24 hours a na Funaral E	edical (	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the niner: On the ba and mann	sis of examina	owledge, deat ation and/or in	th occurred evestigation	at the tin	ne, date an pinion, dea	d place, th occurr	and due to the red at the time	e cause( , date a	s) and i	manner as s e, and due to	tated.  o the cause(s)
L	To the within 2. To the I complete	M	29b. Signature and title of certifier  Cury IV	m			296		o number 0024	92	3	29d. D	ate sign	ned (Month,	Day, Year)
	5		30. Name and address of person who Karen Trent-Mims	completed cause		n 23a) (Type, Greenme					um, MD				
ł	Sta Regist		31. Date filed (Month, Day, Year)	32. Re	egistrar's <del>Signa</del>	ature	00 5								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 09-27th Day 2008 ear **Physician** 1320 Holmes Jr. M. Oscar /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Clinton Southern Maryland Hospital Prince George If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 1,9,48 6. Sex **Funeral** Days 1 XM 2 □ F 240-80-8061 18th North Carolin Director 59 October Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, It was Jeal Examined must be notified at Prince Georg Oxon hill 1 TXYes 2 □ No Director Md 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20745 5702 Fenwood Place USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 🛂No Specify. Specify: Black 3 Widowed 4 Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Director of Operation Private Industry 2yrs 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Oscar M. Holmes Sr. Martha Ann McGougan 19a. Informant's Name/Relationship (Type. Print) (Daughtense (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20745 Tawanna Holmes Crawford 4927 Winthrop Street Oxon Hill Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Harmony Mem Pk CemOct042008 Landover Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service License 20011 NWWashDC Tyrone J. Young 719 Kennedy St. 23a. Part 1 — Ther the disease, or complication of the control of lications that caused the death Approximate Interval Between Onset and Death . Do not enter the mode of dying, such as cardiac or respiratory arrest, Physician CONCESTIVE HEARLI /Medical Due to (or as a consequence of): Examiner ARDIOMYON Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed LIVER CIR attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 ☐ Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ficate has been sign, r, page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 ☑ No certificate 2 No 1 TYes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 2 Accident 5 Pending n 24 hours after death.

The Funeral Director: A pletely filled in by the fu death. investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1/1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the P within 2 To the P 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2008

CR 2

State Registrar 31. Date filed (Month, Day, Year)

OCT 0 2 2008

05114



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

08-07373 Kwamari Harrell Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

		- For State	•	Cert	ificate of	Death				Reg.	No		
Physici		Decedent's Name (First, Midd	ile,Last)						1 84	ate of Death Ionth D	ay Year		Time of Death
ledical Exam		Kwamari Harr	e11						. Se	eptember 2	27, 2008		2137 hrs
		4a. Facility Name (if not instituti		nber)	4	b. City, Tow		cation of I	Death		4c. County of Prince G		
		Prince George's Hos	pital Center			Cheverl	у		0.00			_	
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. las	st birthday)	If Under 1		If Under		Date of Birth	MM/DD/YYYY)	9. Birthr	place (State or Foreign intry)
Director		578-94-1038	1 XM 2 F	36	Yrs		Days	Hours	Min.	March	3,1972	DC	
		Usual Residence of Decedent											
any	1 [	10a. State 10b. County	,	10c. City, 7	own or Locati	ion					,	- 1	10d. Inside City Limits
W .	-	DC		Wash	ington								1 X Yes 2 No
faryland 28a-f show 1 at once.	왕	10e. Street and Number				10f. Zip Co	ode			10g	. Citizen of Wh	at Counti	ry?
eath with the Maryland items 23a or 28a-f sho ust be notified at once	Director	502 44th St.	NF			20	019			11	.S.A.		
vith t	<u> </u>	11. Marital Status		edent Ever in U.S	5. 13. Wa	s Decedent	of Hisp	anic Origir	n? (Specify	y Yes or No-	14. Race		an Indian, Black,
ath v item	Funer	1 X Never Married 2	Married Armed Fo	orces?	If Y	es, specify (	Cuban,	Mexican, I	Puerto Rica	an, etc.)	White	e, etc.	
ier de		3 Widowed 4 D	ivorced If Yes, Give Yea		1	Yes 2 x	No	specify:			Specify:	Blac	k
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2 hou	ompleted	Elementary/Secondary (0-12	2) College (1	-4 or 5+)	dunng m	ost of working	ig lite. I	JO NOT U	ise retired)	0.00			ľ
336 thin 7 than than	힐		2		Federa	al Pol					U.S. G		
5-0036 led within 72 Hygiene. tother than 'the Medical	S	17. Father's Name (First, Midd	e, Last)				1	8. Mother's	Name (Fir	st, Middle, Ma	aiden Surname	)	
		Joseph Harrel	1, Sr.					Mary	v Wils	son	er, City or Tow		
MD 21215-0036 d 2 should be filed within 7 lith and Mental Hygics in 27 is marked other than ampaire event, the Medics	2	19a. Informant's Name/Relatio	nship (Type, Print )	•	1								Zip Code)
AD 12 sh th and 127 i		Mary Harrell	Mother		502	<u>44th S</u>	t.,	NE,	Wash:	ington	DC 20	019	Faura Chata
		20a. Method of Disposition	Domewol fr		Place of Dispo	sition (Name ther place)	of cem	etery,	Da	ate	20c, Location	- City or	lown, State
imore, MD 2121 Pages I and 2 should be fit ment of Health and Mental tant: If item 27 is many or other traumatic event,		1 Burial 2 X Cremati		Fr	Linc	oln Cr	ema	tory	10/5/	/2008	Brentw	rood,	MD
Baltimore, permit. Pages 1 at Department of He Important. If ite injury or other tr	1	21. Signature of Funeral Servi		4							ln Fune		
Ba Pern Dep Imp		ilum	Ox . Car	uli-	_ 3	401 B1	ade	nsbu	rg Rd.	., Bre	ntwood,	MD	20722
Physician	1	23a. Part I. Enter the disease,	or complications that	aused the death.	Do not enter	the mode of	dying, s	such as ca	ardiac or res	spiratory arres	st, shock, or he	eart	Approximate Interval Between Onset and
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87 tifica ing pl		23b. Was decedent pregnant in past 12 months?	1		_	etal death	3	Ectopic	pregnancy	у	Month		Day Year
OX 68's sath certifications	/sician		Halimanian T	nant at time of de	eath 5 (	Other (Speci	fy)						
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s, P.O. Beines that the de	by F	Part II. Other significant con	iditions contributing	to death but not r	estricing in the	e underlying	ause g	nven m r c	21 ( 1.				pably 4 Unknown
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n: TI	<u> </u>	25. Was case referred to med	tical			2	6.Place	of Death	(Check onl	ly one)			
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Division of Vital Records, P.O. Box 687 tall or Attending Physician: The law requires that the death certifing are clean.	[   누	27 Manner of Death	28a. Dat	e of Injury	28b. Time o	of Injury 2	8c. Inju	ry at Worl			now injury occu	irred	
r finding		1 Natural 5 F	ending	th, Day Year) 7, 2008	2103 hrs	1	1	Yes 2 ✓	No St	ubject sho	ι		
isic Atte		2 Accident In	nvestigation 28e. Pla	ace of Injury - At h	nome, farm, st	reet, factory,	office b	ouilding, e	tc. 28	8f. Location (	Street and Num	ber or R	ural Route Number, City
Distriction	ertification;	3 Suicide 6 0	Could not be    letermined   (Specifi	Local Stre	et				46	or Town, S 304 Kane Pl	itate) ace NE, Was	shington	, DC
lospii 4 hour	=   ບ	20a Cartifica	- Physician: To the h	est of my knowled	toe death occ	curred at the	time, d	ate and pl	ace, and du	ue to the caus	e(s) and mann	er as sta	ted.
Division To the Hospital or Attend within 24 hours after death To the Funceral Director:	completely filled in by the ledical Certification	(Check only one) 2 ✓ Medical	Examiner: On the basis	s of examination	and/or investig	gation, in my	opinior	n, death o	ccurred at ti	he time, date	and place, and	due to ti	he cause(s)
To To	Med	29b. Signature and title of ce	and manner	stated.				se number					onth, Day, Year)
		$\cap$	111	16			O.C.	M.E.			Septemb	er 28, 2	2008
11		30. Name and address of per	reon who completed as	use of death (Item	m 23a)		_						
·R 12			Deputy Chief Med			enn Stree	t, Bal	ltimore,	MD 212	201			
/	Stat	a 31. Date filed (Month, Day, Ye		Registrar's Sign									
Pos	stat istra	0000	Kanne	N A	1								

			State of N	laryland /	Depar	tment of He	ealth and I	Mental Hy	giene		
		•	1 - State Registrar		Cert	ificate of E	Death		Reg. No.	2008	3.3515
	Diii		1. Decedent's Name (First, Middle, Last)					2. Date of De Month	ath Day	Year	3. Time of Death
	Physicia /Medic	- 8	Vanessa Hicks					Septem			8 12:30 A <sup>M</sup>
	Examin	1 4	4a. Facility Name (If not institution, give street and number	r)		4b. City, Town, or	Location of Death	1	4c. C	ounty of Deat	h
-			Manor Care Nursing Home			Potom				Montgo	
	Funeral		5. Social Security Number 6. Sex 7. / 1 ☐ M 2 🗓 F	Age (In yrs. last		If Under 1 Year Months Days	Hours Min.	8. Date of Bir (Month, Da	y, Year)	Co	hplace (State or Foreign untry)
١	Director		578-74-4570 Usual Residence of Decedent	54	113.			Dec 7,	1953	Vi	rginia
	land	ŀ	10a. State 10b. County	10c. City, To	own or Loca	ation					10d. Inside City Limits
	Mary f sho	ē	Maryland Montgomery	Rock	ville						Mg Yes 2 □ No
	r 28a	Director	10e. Street and Number			10f. Zip Code			10g. Citize	en of What Co	untry?
	3a ou		705 Monroe Street, #103			20850			Unit	ed Sta	tes
	hours after death with the Maryland tural", or items 23a or 28a-f show al Examiner must be notified at	Funeral	11. Manital Status 12. Was Deceder Armed Force:	nt Ever in U.S.	13. W	as Decedent of His Yes, specify Cubar	spanic Origin? (S	pecify Yes or No		4. Race - Ame	rican Indian,
٥	after or ite		1 Never Married 2 Married 1 ☐ Yes 20 If Yes, Give			res, specily Cubai □Yes 27,□No	Specify:	o nican, etc.)		Black, White	e, etc.
0036	ral", c	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates	3:		2 165 2 140	эреспу.		3	Specify: B	lack
ק	72 he	Completed	15. Decedent's Education (Specify only highest grade completed)	11	6a. Decede (Give k	ent's Usual Occupa ind of work done d O NOT use retired)	ation Juring most of wor	rking	16b. Kind	d of Business/	/Industry
Z	ithin ne. han *	ם	Elementary/Secondary (0-12) College (1-4c	r 5+)					_		
N	led w lygie her ti		12 years 17. Father's Name (First, Middle, Last)			<u>Care Give</u>	18. Mother's Nar	no (Eiret Middle		rivate	
and	be fi	Be	, , ,					es Jone		umame)	
چ	d Mel narke natic	ပ	Arthur Hicks  19a. Informant's Name/Relationship (Type. Print)		IOh Mailine	Address (Street a				Tawn State	Zin Cada)
Ma	d 2 sl th an 7 is r traur		Juletta Mims - Niece	'	-	Long Ri					Lip Odde)
ص ص	1 and Healt em 2 Ather		20a. Method of Disposition	20b. Place		ition (Name of atory or other place		Date		ation - City or	Town, State
Бащтог	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from Sta			atory or other place ematory	1	8/08			inton, MD
	nit. Partme		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee	1 lice		Name and Addres			Funer		•
ğ	Department and and and		Man W. Stario	nother	7 124	001 Benni					
	K-1-7-119		23a. Part 1. Inter the disease, or complications that caus shock or heart failure. List only one cause on each	sed the death. D							Approximate
S	Dhysisian										Interval Between Onset and Death
	Physician Medical		disease or condition resulting in death) a. Due to (or	as a consequen	ce of):	ia e lve					
	Examiner		9	2 hair	taca	e CIVEI	2 dis	east.			
	*	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	as a consequen	es ory: 0						
	cuted id ansit	Examiner	Cause (Disease or injury that initiated events								
o,	e exe	EX	resulting in death) Last Due to (or	as a consequen	ce of):						
8/60,	ificate be executed g physician and is the burial-transit	dical	d								
٥	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Med	IF FEMALE:								
ROX	eath certific attending p for use as	Physician/Me	23b. Was decedent pregnant 23c. If yes, outcome in the past 12 months?	ı 2 ☐ Fetal de	ath 3	Ectopic pregnancy			23	3d. Date of de Month	livery Day Year
5	e deg	sici	1  Yes 2 No 4 Pregnan 9 Unknown 9 Unknown	t at time of deatl	h 5□	Other (specify)				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	24,
Ţ.	uires that the de signed by the a Id be detached f	Phy	Part II. Other significant conditions contributing to death	hut not resultin	o in the un	derlying cause give	en in Part I	23e Did	tobacco us	se contribute t	o the cause of death?
Š	ires ti signe	by	Tarti. Other significant conditions contributing to dead	t but not resultin	ig in the an	aonymig daado give	511 11 1 Care 1.		Yes 2□		robably 4 🖂 nknown
Ö	w require been sign	eted									
Records,	e law has b e 2 s	Completed						24a. Was	s an ipsy ormed?	24b. Were a prior to death?	utopsy findings available completion of cause of
<u>=</u>								1□ Yes	2 No		s 215(No
Vital	sician: certifica rector,	Be	25. Was case referred to medical examiner?  Hospital:			2D DOA Othe	ar.	ath (Check only			
ō	ttending Phys Jeath. :tor: After this (	1°	1 ☐ Yes 2 2 1 1 ☐ Inp 27. Manner of Death 28a. Date of I		Outpatient  Bb. Time of	3 DOW	4 PA Nursing I	Home 5 ☐ Res 28d. Describe			ecify)
	ding  After fune	ion	1 Natural 5 Pending (Month,	Day Year)	Injury	28c. Injun Work M 1 1	k? Yes 2 ∐ No	200. 2000.	,,,,,,,	35541154	
<u>:</u>	Atten deatl ctor: y the	ical	3 Suicide 6 Could not be determined 28e. Place of	injury - At home	e, farm, stre	et, factory, office		28f. Location	(Street and	Number or F	Rural Route Number,
DIVISION	after after Dire	Certification:	4 ☐ Homicide determined building	etc. (Specify)				City or To	iwn, State)		
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,		29a. Certifier Certifying Physician: To the be								
	n 24 n 24 n Fu	edical	(Check only 2 Medical Examiner: On the basi and manner		and/or inv	estigation, in my o	pinion, death occ	curred at the time	, date and	place, and du	ie to the cause(s)
	To the To the Comp	M	29b. Signature and title of certifier			29c. License			29d. Date	signed (Mon	nth, Day, Year)
						00	05456	6	91	2810	8
•			30. Name and address of person who completed cause of	of death (Item 23	Ba) (Type, F	Print)					
2	5		Sunitha Bhogavilli, a	1801 a	1000	iaAvin	m #1-1	7,511	vensr	מרוורי	MD Z0902
1	Sta		31. Date filed (Month, Day, Year) 32. Reg	istrar's Signatur	و مارين	Ę		/	- 0	')	
	Regist	ar	OCT 0 7 2008	N 14		Print) Lia Avin					
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DHMH 17 Rev 1/2001

			1 For State	State of Ma		d / Depa	artmen	t of H	ealth a		ental Hy			•	
	Physici	an.	State Registrar  1. Decedent's Name (First, Middle, Last	)		Cei	rtificate	e ot E	eath		Date of De Month	Reg. No eath Day	200		Ime of Death
1	/Medic	al	ALWANA MINNIE HAM 4a. Facility Name (If not institution, give				4b. City,	Town, or	Location o	of Death	10/1/	2008		2:	43 PM <sup>M</sup>
	Funeral Director		MANOR CARE NURSING  5. Social Security Number  6. Se			last birthday) Yrs.	LARG If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	th ay, Year)		Birthplace (S Country)	State or Foreign
May 1	D		578–38–6479           Usual Residence of Decedent           10a. State         10b. County		81 10c. Cit	y, Town or Lo	ocation				12/19	/192	о ка	leigh	side City Limits
	h the Man r 28a-f sh notified	Director	DC  10e. Street and Number		Was	hingto	on 10f. Zip	Code				10g. Cit	izen of What		Yes 2 No
	ath with 23a o	ralD	4366 F. Street					2001					ited St		
920	ges 1 and 2 should be filed within 72 hours after death with the Maryland tr of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☎ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	ver in U.		Was Deced If Yes, sped 1 ☐ Yes 2				cify Yes or No Rican, etc.)	)-	14. Race - Ar Black, Wi Specify: B1	hite, etc.	ian,
Maryland 21215-0036	ithin 72 ho ne. nan "natur e Medicol E	Completed	15. Decedent's Edu (Specify only highest grad	cation le completed) College (1-4or 5-	·)	(Give life.	dent's Usua kind of wor DO NOT us	al Occupa k done d e retired)	ution uring mos	t of worki	ng		ind of Busines	ss/Industry	
d 21	filed w Hygier ther th	Col	12 17. Father's Name (First, Middle, Last)			Nursi	.ng		18. Mothe	er's Name	(First, Middle		ivate		
lan	Mental arked o	To Be	William C. Jeffrie	es.							Allen		,		
	and 2 should teath and Menter in 27 is marked ner tranmatic	'	19a. Informant's Name/Relationship (7) Nathaniel Hamiltor	rpe. Print)							Route Numb				)
Baltimore,	Pages 1 and 3 nent of Health ant: If item 27 ury or other tra		20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ F	Removal from State		Place of Dispo emetery, crea	sition (Nan matory or o	ne of ther place	9)	D	ate	20c. Lo	ocation - City	or Town, St	
altir	+ せぜき		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service License		Ме	tropo1					2008   e Funer		xandri Homes,		•
<u>~</u>	permi Depa Impo any ir		KATA. A.	angeMi	ilus	5 5	538 Ma	rlbc	ro P	ike	Forestv	7 <b>i</b> 11€	Mary	z] and	20747
	Physician /Medical		23a. Pabr. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ne cause on each line a. <u>CARDIOP</u>	ULMU	NARY F			j, such as	cardiac o	r respiratory a	irrest,		Interv	oximate val Between et and Death
	Examiner			Due to (or as a		555									
	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c. ATRIAL			N								
760,	eath certificate be executed attending physician and for use as the burial-transit	cal Ex	resulting in death) Last	Due to (or as a	conseq	uence of):									
× 68	ertifical ling phy e as th	Medi	IF FEMALE:	20- 17											
P.O. Box	The law requires that the death certifica ate has been signed by the attending phagge 2 should be detached for use as the	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome p 1 □Live birth 2 4 □ Pregnant at t 9 □ Unknown	Feta	Ideath 3	⊒Ectopic pro ⊒ Other (sp						23d. Date of o Month	delivery Day	Year
ds, P	juires that the de n signed by the a ld be detached f		Part II. Other significant conditions co PRESSURE ULCERS	ntributing to death bu	not resi	ulting in the u	nderlying ca	ause give	n in Part I.		23e. Did 1		use contribute		se of death?
Records,	The law require te has been siç age 2 should b	Completed by									24a. Was auto perfo		prior 1	to completion?	dings available on of cause of
Vita	cian; ertifica ctor, p	Be C	25. Was case referred to medical examiner?						26. Place	of Death	1  Yes (Check only o		101	es 2□N	
	or Attending Physician: The after death.  Director: After this certificate he in by the funeral director, page	၉	1 ☐ Yes	Hospital: 1 ☐ Inpatier 28a. Date of Injur		ER/Outpatier 28b. Time o			4 😾 NU		ne 5 ☐ Resi 28d. Describe			pecify)	
ion	arth. arth. or: Afte	ation	1X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year)	Injury	М	8c. Injury Work 1 ☐ Y	? ′es 2 🔲				, , , , , , , , , , , , , , , , , , , ,		
Division or	tal or Attencs after deathal Director;	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injurbuilding, etc.	y - At ho (Specif	ome, farm, str	eet, factory	, office		2	28f. Location ( City or To	Street ar wn, State	nd Number or e)	Rural Rout	e Number,
	To the Hospital or A within 24 hours after To the Funeral Direction of	edical (	29a. Certifier (Check only one)  1 ☑ Certifying Phy 2 ☐ Medical Exam	sician: To the best o iner: On the basis of and manner stat	examina	wledge, deat tion and/or in	h occurred vestigation	at the tim , in my op	e, date ar pinion, dea	nd place, ath occurr	and due to the ed at the time	cause(s , date an	) and manner d place, and d	as stated. due to the c	ause(s)
	To the within 2	Σ	29b. Signature and title of certifier				29c	. License	number			29d. Da	te signed (Mo	onth, Day, \	(ear)
	2		30. Name and address of person who co	myleted cause of de	ath (Ita~	23a\ /Tunc		515	520			10,	/3/2008	3	
1			Bahram Pishdad, M		,		,	5.E.	Wash	ingt	on, D.(	C. 20	0032		
	Sta Registr		31. Date filed (Month, Day, Year)  OCT 0 7 2008	a 32. Registra			ï								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 335 L 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 3:43 PM Forrest Harris October 5 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner of Maryland Medical Center Baltimore University If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1₽M 2□F Months Days Hours Min 230-66-8833 Director 10 /08/1949 Petersburg, Usual Residence of Decedent Maryland 10c. City, Town or Location 10a. State 10b. County 10d, Inside City Limits 28a-f show must be notified at Maryland Prince Georges Bowie 1 Yes 2 No Director permit. Pages 1 and 2 should be filed within 72 hours after death with the N Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-fany injury or other traumatic event, the Medical Examples or other traumatic event, the Medical Examples or 28a-fano. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12612 Craft Lane 20715 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married Black 1 ☐ Yes 2 ☐ No Specify. þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) <u>Resource Specialist</u> Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert P. Harris Hester Wooden 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce B. Harris 12612 Craft Lane Bowie, Md. 20715 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1

☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Ft. Lincoln 10/9/2008 Brentwood, Md. 21. Signatuje of Funeral Service Licenses 22. Name and Address of Facility
Alexander S. Pope P.A.
5538 Mariboro Pike/Forestville, Md. 20747 Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due to (or as a or request of): **Physician** disease or condition resulting in death) 18 nonths /Medical Examiner metastatic prostate Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine the Hospital or Attending Physician; The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Sacteremia 1 Tes 2 No 3 Probably 4 Vunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has birector, page 2 s autopsy performed? 1 ☐ Yes 2 ☐ No 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 2 1 N Inpatient this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No neral Director: / 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide after within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

State Registrar

29b. Signature and title of certifier

ENNIFEL BROWN 31. Date filed (Month, Day, Year) 32. Registrar's Signa -2008 7

30. Name and addless of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

GREENS ST BALTIMORE MD

, M.D, Physidan DEA # AUY176435B17453

29d. Date signed (Month, Day, Year)

10/05/2008

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Raymond J. Hynson October 2008 3:10 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9824 Cypressmede Drive Ellicott City Howard If Under 1 Year | If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign 6. Sex Date of Birth (Month, Day, Year **Funeral** Months Days Hours Min 1⊠M 2□F Director 214 20 3261 81 Nov 27, 1926 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show notified 1 ☐ Yes 2 XNo Directo Ellicott City MD Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò must be 23a 9824 Cypressmede Drive 21042 United States Funeral death Item 27 is marked other than "natural", or Items other traumatic event, the Medical Examiner mi 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Armed Folces:

18 Yes 2 No
If Yes, Give
Year or Dates: 1944-46 filed within 72 hours after 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. <u>م</u> Specify: 3 Widowed 4 Divorced White Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) al Hygiene. 5+ Self Employed Attorney 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any Injury or other traumatic event Peter S. Hynson Anna E. Dietz 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Esther M. Hynson/Wife 9824 Cypressmede Drive Ellicott City, MD 21042 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State P Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery 10-7-2008 Baltimore, MD 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licenses M01044 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Metastatic Pancreatic **Physician** /Medical Examiner Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed Hypertens ion physician and s the bunal-trans Hyperlipidemia P.O. Box 68760 cal Physician/Medi IF FEMALE: for use If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) 1 ☐ Yes 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of s certificate has b irector, page 2 sl 24a. Was an performed death? 2□ No 2X No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) 1 ☐ Yes 2K No Certification: To 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of After 1 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury death. 1 □ Yes 2 □ No after death Director: / 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours at To the Funeral Completely filled in 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) remach Ma October 3, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wilkens Ave #100, Baltimore, MD 21229 Modi Seema 31. Date filed (Month, Day, Year)

OCT 0 6 2008 State Registrar

DHMH 17 Rev 1/2001

Physician /Medical Examiner law requires that the death certificate be executed burial-trar and Division or Vital Records, P.O. Box 68760, attending physician the

permit. Pages Department of Important: If it any Injury or o

**Physician** 

/Medical

Examiner

Director

Funeral

by

Completed

Be

**Funeral** 

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Int: If item 27 is marked other than "natural", or items 23a or 28a-f show

the Medical

Saltimore, Maryland 21215-0036

þ pe page 2 should director After 24 hours after death Funeral Director: filled in by the

Physician:

Hospital or Attending

this

Physician/Medical þ Completed

Be

Certification: To

Medical

completely within 2.

2

29a. Certifier

Examiner

27. Manner of Death 5 ☐ Pending investigation Natural 2 Accident 6 ☐ Could not be 3 ☐ Suicide determined 4 Homicide

> Kertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28a. Date of Injury 28b. Time of (Month, Day Year) Injury

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

29b. Signature and title of certifier

0 1 2008

MO

of de th Item 23a) (Type, Print) 30. Name and address of perion

1100 North Capitol St NE Washington, DC 20002 led (Month, Day, Year)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 33520 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** O'Es Margaret Μ. Hambruch 1030 /Medical 4a. Facility Name (If not institution, give street and number) 4b City Town or Location of Death 4c. County of Death Examiner wicomico POUNDING BEGONAL MEDICAL CIENTER If Under 24 Hrs. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In vrs. last birthday Birthplace (State or Foreign) **Funeral** Months Days Hours Min. 1 □ M 2 X F Maryland 214-42-2285 66 Director Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show injury or other traumatic event, the Medical Examiner must be notified at Director 1 XYes 2 □ No Maryland Salisbury Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 72 hours after death with 30372 Cannon Drive 21804 USA 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛂 No If Yes, Give Year or Dates Specify: þ white Specify: 3 Widowed 4 Divorced "natural". Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within 7 I Hygiene. than, Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic d 2 should be filed with and Mental Hygier 7 is marked other the 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Samuel Knight Louise Reynold ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health an Important: If item 27 is n any injury or other traur William Hambruch/husband 30372 Cannon Dr., Salisbury, MD 21804 20b. Place of Disposition (Name of cemetery, cramatory or other plants of Cardens Gardens 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/3/08 Hebron, MD 22 Holloway Funeral Home Professional Associaiton 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ARDS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Myocardial Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to or as a conse juence of : law requires that the death certificate be executed ORD and burial-trar Due to (or as a consequence of): Box 68760. physician Physician/Medical the ası attending properties for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 menths? Month Year Day 5 Other (specify) P.O. the 9 Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ò 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy Division of Vital 2 No 2 No 1 ☐ Yes Physician: director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No 1 Inpatient Other: 4 \( \text{Nursing Home} \) 5 \( \text{Pesidence} \) Residence \( 6 \) Other (Specify) 2 ER/Outpatient 3 DOA this Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death. 5 ☐ Pending investigation 1. Natural
2 Accident thin 24 hours and the Euneral Director: Af 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 🛮 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 0 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D41721 08

Registrar DHMH 17 Rev 1/2001

State

5. SHONE

DR

SALUBURY

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

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2008

STEPHAN

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month ()9 **Physician** 2008 Vermelle Elizabeth Jones 10:05a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5105 Trinidad Street Riverdale Prince George's 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 06/26/1924 5. Social Security Number 9. Birthplace (State or Foreign Funeral Months 1 □ M 2 🖾 F Days Hours Min. Washington, DC 84 Director 579-26-8870 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County death with the Marylar permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinational be published at once. Maryland Prince George's Riverdale Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20737 USA 5105 Trinidad Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 2**X** No 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 Black 1 ☐Yes 2 XNo Specify: Specify. þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Military Specialist Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Theresa Elizabeth Gantt Rhody Arnold McCoy 0 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5105 Trinidad St., Riverdale, MD Antoinette Jones-Farley - Dtr. 20737 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cem. 10/03/2008 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Fort Lincoln Funeral Home 3401 Bladensburg Rd., Brentwood, MD 20722 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Abdominal Aortic Aneurysm **Physician** months disease or condition resulting in death) /Medical Due to (or es a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter drivering Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) burial-1 Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🔁 No Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypertension 1 TYPes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an s certificate has b irector, page 2 s autopsy 1 ☐ Yes 2 🖾 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) s after death.

I Director: After this ce
of in by the funeral direc Other: 4 ☐ Nursing Home 5₺ Residence 6 ☐ Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide n 24 hours af e **Funeral D** fetely filled ii 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier within 24 hou

To the Fune

completely fi Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10/01/2008 D29353 nuas 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) George W. Graves, MD, 5530 Wisconsin Avenue, Chevy Chase, MD 20815 32. Registrar's Signat 31. Date filed (Month, Day, Year) State 2008

Registrar

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		Registrar Amend #5PerFHPQC10-7-08cr  1. Decedent's Name (First, Middle, Last)			Dealli	2. Date of Dea	Reg. No. C	3. Time of Death
Phys		David Earl Joyner, Sr.						2008 2:00 P M
	dical niner	4a. Facility Name (If not institution, give street and number)		4b. City, Town, o	r Location of Death		4c. County	
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pu:		Usual Residence of Decedent  10a. State 10b. County 10c. Cit	y, Town or Lo	cation				10d. Inside City Limits
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To the Hospital or Attending Physician: The law requires that the death certificate by within 24 Hours after death.  To the Hours after death.  To the Funeral Director: After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the but		29a. Certifier (Check only 2   Medical Examiner: On the basis of examina						
the the thin 2, the mplet	Medical	one) and manner stated.  29b. Signature and title of certifier		29c. Licens	oo numbar		20d Date signer	(Month, Day, Year)
<b>₽</b> ₹ <b>₽</b> 8		29b. Signature and the or certifier		D C	C7000		29d. Date signed	9012,008
A		30. Name and address of person who completed cause of death (Item	1 23a) (Tvne	Print)	3 (800			712000
K 2		29b. Signature and title of certifier  30. Name and address of person who completed cause of death (Item  MUHAMMAD HSHRAF 5  31. Date filed (Month, Day, Year)  OCT 0 3 2008  32. Registrar's Signa	111 Sa	ws ave	une # 10	O RIVE	edale,	MD20737
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene **Physician** /Medica Examine Funeral Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Madical Examination in profitting at once. Baltimore, Maryland 21215-0036 Physician /Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

	•	1 - State Registrar	ertificate of L	Death		Reg. No. 2	008	33523		
		1. Decedent's Name (First, Middle, Last)			***	2. Date of De Month	ath	Year	3. Time of Death	
Physici: Medic/	ALAN CHARLES JUBA SEPTEMBER 30, 2008   9:3								9:36A <sup>M</sup>	
Examin		4a. Facility Name (If not institution, give street and number)  ANNE ARUNDEL MEDICAL CENTER		4b. City, Town, or ANNAPOL			4c. Col	unty of Death E ARUN	DEL	
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or 28	Director	10e. Street and Number		10f. Zip Code	•	10g. Citizen of What Country?				
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Items	Funeral	11. Marital Status  12. Was Decedent Ever in Armed Forces?  Armed Forces?	1 U.S. 13	B. Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No Rican, etc.)		Race - Ameri Black, White,		
Department of front and worked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, it a Mexical Exactive must be realised at once.	ρ	1 Never Married 2 Married 1 Yes 24 No If Yes, Give 3 Widowed 4 Divorced Year or Dates:		1 □Yes 2 No	ecify: WHI	TE				
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State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Yeer 1410 M **Physician** 25,2008 september CARLISS POLLOCK JACKSON /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner If Under 1 Year | If Under 2 Hrs. 6 cores Trince HOS Birthplace (State or Foreign Country) 8. Date of Birth (Month, Dey, Y 4/2/1941 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number Days **Funeral** Hours Min. 1 ☐ M 2 🛛 F Lexington, KY 67 Director 578-56-2024 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h County r than "natural", or Items 23a or 28a-f show the Medical Examinar roust be notified at ty⊡Yes 2 ☐ No Director Washington DC 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20020 2215 31st Street S.E. 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No hours after 1 ☐ Never Married 2 € Married Specify: Black 1 ☐ Yes 2 ☑ No Maryland 21215-0036 If Yes, Give Year or Dates: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education filed within 72 (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Government Personell Staffing Specialist 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Ith and Mental H 27 is marked of traumatic sver Pages 1 and 2 should be Leona Palmer John Wesley Maddux 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a Important: If item 27 is eny injury or other trau once. Spouse 2215 31st St. S.E. Washington, D.C. 20020 Clifton E. Jackson Sr. Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Fort Lincoln Cemetery 10/2/2008 Brentwood, Maryland \* 4 □Donation 5 □Other (Specify) permit. 21. Signa a e of Funeral Service Lic. 22. Name and Address of Facility Pope Funeral Homes, P.A. 23a. Patr1. Eher the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 5538 Marlboro Pike Forestville, Maryland 20747 Immediate Cause (Final disease or condition resulting in death) Atherose Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): physician Box 68760 Physician/Medical the IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months?
1 Yes 2 No 5 Other (specify) 4 Pregnant at time of death o 9 Unknown 9 TUnknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. δ 3 Probably 4 Donknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate has 1 ☐ Yes 2 No 2 11No 1 ☐ Yes or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical funeral director Be Other: Hospital: 2 ≃ ER/Outpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 🗀 Inpatient 3 DOA Certification: To this 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death After 5 Pending investigation 1-Natural 1 ☐ Yes 2 ☐ No М death. 2 Accident within 24 hours after death To the Funeral Director: the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 🗋 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 🗋 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

We Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier

DHMH 17 Rev 1/2001

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SALVAdor 31. Date filed (Month, Day, Year)

1 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #1 Per PHY G884 10/31/08 JH
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Annie Elaine Keeney **Physician** October 14ay 2008 ar 9:45 AM M Annie-Flizabeth /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Frederick Northampton Manor Health Care If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Sept. 2, 1938 9. Birthplace (State Sept. 2, 1938 Mary Land 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Min. 1 ☐ M 2 💢 F 220-34-0049 70 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exercise must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1X Yes 2 □ No Walkersville Director Maryland Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21793 U.S.A. 61 West Frederick Street Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 2 XXX0 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1∐Yes 2**∭X**o Specify: ò Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hospital Administrative Assistant 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Annie Elizabeth Hann Oscar Martin Summers ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
61 West Frederick St., Walkersville, MD 21793 19a. Informant's Name/Relationship (Type. Print) Walter K. Keeney, husband Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Clustered Spires Cem. Oct. 17, 2008 Frederick, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura of Funeral Service Lic. 22 Keenev and Fastord PA Funeral Home MO0255 106 East Church St., Frederick, MD 21701 23a. Part 1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cancer of the Lung **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying (155 and 151) that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Diabetes Mellitus 1 X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Hypertension 24a. Was an certificate has lirector, page 2 s autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 【No o 24 hours after death.

Funeral Director: After this certific letely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier within 24 hou To the Fune completely fil and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number MD October 14, 2008 D 0054636 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Syed W. Haque, M.D., 700 Montclaire Ave., Frederick, MD 21701 32. Registrar's Signature 31. Date filed (Month, Day, Year) State OCT 21 2008 Made 8 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** October 02 2008 02:28 A M August C. Klaes /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Greater Baltimore Medical Center Towson If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1**√**2 M 2 □ F Director 10/19/1929 Pennsylvania <u>579-26-5804</u> Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits death with the Marylan 10a State ral", or items 23a or 28a-f shov Yes 2 No Howard Director Maryland Jessup 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20794 USA 7853 Sellner Road Trailor #1 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No White Specify: Completed by 3 Divorced "natural" 7 Is marked other than "nature traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Driver Federal Armor Express 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William F. Klaes Lyida Walker Pages 1 and 2 should nent of Health and Mer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20794 Joyce A. Klaes - Wife 7853 Sellner Rd., Trailor #1, Jessup, MD Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Department of Important: If it any injury or conce. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cem. 10/07/2008 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Fort Lincoln Funeral Home 3401 Bladensburg Rd., Brentwood, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Acute Myocardial interestion **Physician** disease or condition resulting in death) /Medical Examiner leural affusion Adenocarcinona Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) Division of Vital Records, P.O. 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe performed? 1 ☐ Yes 2 ☐ No ·bx 1 ☐ Yes 2 ☐ No Atrice TIOK director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No thin 24 hours after death.

the Funeral Director: A

mpletely filled in by the fu investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. within 2

To the F

complet 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 10/03/2008 20064303 6701 N. Charles St 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore Medical Center Towson, MD 21204

State Registrar

31. Date filed (Month, Day, Year) OCT 0 7 2008

Hmu



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day Year **Physician** OCT. 1 2008 1410 M KENNEY WILLIAMS PATRICIA ANN /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Rockville MONTGOMERY Shady Grove Adventist Hospital If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. Months 1 □ M 2 🔀 F 53 Maryland July 4,1955 Director 219-64-5284 Usual Residence of Decedent death with the Maryland 10d Inside City Limits 10c. City, Town or Location 10a State 10b County 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Gaithersburg Director MD Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 23a or U.S.A. 20878 847 Flagler Drive Funeral items ? 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene.

is marked other than "natural", or iter 1 ☐ Yes 2√2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: ģ Specify: Black 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) Montgomery Co Elementary/Secondary (0-12) College (1-4or 5+) Public Schools Bus Attendant llth 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Edward C. Williams, Sr Alice Green ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2090419a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important; If Item 27 is any injury or other trau 3408 Robey Ter, Silver Spring, MD #302 Erika Prather (Daughter) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State 10/11/08 Silver Spring,MD Gate of Heaven Cem 4 Donation 5 Other (Specify) 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 21. Signature of Funeral Service 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Wecks Immediate Cause (Final **Physician** Gram Negative Sepsis disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** weeks Pneumonia Sequentially list conditions, Examiner Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last requires that the death certificate be executed and use as the burial-trar Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☑ No for 4 Pregnant at time of death 5 ☐ Other (specify) detached 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ð cate has been sign page 2 should be 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Cirrhosis Completed 24b. Were autopsy findings available prior to completion of cause of death? Hepatitis C 24a. Was an autopsy performed' 1 □Yes 2X No 1 ∐Yes 2 ∐No Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 **∀**o 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 5 Pending investigation or Attending 1 Natural
2 Accident 1 ☐ Yes 2 ☐ No 24 hours after death. • Funeral Director: A 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical completely (Check only and manner stated. within 24 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 10/1/08 D38262 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2401 Research Blve, Ste 330, Rockville, MD 20850 Mendniratta, M.D. 32 Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Registrar

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2008

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death sept. 29 2008 11:09 AM Robin Lynn King 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) Months Days Hours 1 ☐ M 2 💢 F 098-68-4738 40 May 10,1968 New York Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County Anne Arundel Arnold 1 Tyes 2 X No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21012 281 Overleaf Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Black, White, etc. 1 □Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 X No Specify. 3 Widowed 4 X Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Vocational Services Elementary/Secondary (0-12) 12 College (1-4or 5+) Company Human Resources Assistant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Earl A. Hayes Kathleen Pearl Yager 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 48 Raintree Drive Sicklerville, NJ 08081 19a. Informant's Name/Relationship (Type. Print) Earl A. Hayes / Father 20b. Place of Disposition (Name of Atlantic Crematory of Other place) Atlantic Crematory LLC Oct. 03, 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Glen Burnie, MD 2008 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Barranco & Sons, P.A. 495 Gov. Ritchie Hwy, 21. Signature of Funeral Service Liour see P.A. Severna Park Funeral H Severna Park, MD 21146 art . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedir te Cause (Final MYOCARDIAL MINUTES disease or condition resulting in death) Due to (or as a consequence of): IABETES Sequentially list conditions, if any, leading to infime find cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknowr 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? /es 2 No 1 ☐ Yes 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation

Examine sician and burial-transit b Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
b Hours after death.
certificate has been signed by the attending physician and Box 68760 attending physician Physician/Medical the for use as signed by the a P.O. Division of Vital Records, cate has been si Completed director, Be Certification: To funeral

**Physician** 

/Medical

Examiner

**Physician** 

/Medical

**Examiner** 

10a. State

Director

Funeral

Completed

Be

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MD

**Funeral** 

Director

28a-f show

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Wydigal Exprised. until be confided and once.

Maryland 21215-0036

altimore,

completely filled in by the

Medical To the within 2

Registrar

and manner stated. 29b. Signature and title of certifier

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MEDICAL PKWY, ANNAPOLIS, MD 2140

31. Date filed (Month, Day,

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

<sup>Year)</sup> 2008 OCT 0

6 Could not be determined

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

		1 - State Registrer	State of Mai	ryiaiiu / L	Certificate of I		, ,	Reg. No. O. O. O.	
Physicia	an	1. Decedent's Name (First, Middle, L			V		Date of Dea     Month	th Day Yes	3. Time of Death
/Medic		George	Melvi	Ln	Kegg			BER 30, 2	008 16:00 <sup>™</sup>
Examin	er	4a. Facility Name (If not institution, g				Location of Death		4c. County of D	
Funeral		WMHS - MEMORIAL  5. Social Security Number 6.		(In yrs. last bir		If Under 24 Hrs.	8. Date of Birth	ALLEGAN 9.	Birthplace (State or Foreign
Director		188-20-8318 Usual Residence of Decedent	1 <b>∏</b> M 2□F 8	30	Yrs. Months Days	Hours Min.	8. Date of Birth (Month, Day 12/11/	1927 Pe	ennsylvania
yland iow at		10a. State 10b. County		10c. City, Tow	n or Location				10d. Inside City Limits
a-f sh	ctor	MD Al:	legany		Cumberland	i			1 ☐ Yes 2 🂢 No
permit. Pages 1 and 2 should be flied within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	10e. Street and Number 11513 Valle	y Road, NE		10f. Zip Code	21502		10g. Citizen of What ՄՀ	-
ter death Items 2 iner mus	-uner	11. Marital Status 1 □ Never Married 2 🔯 Married	12. Was Decedent Ev Armed Forces? 1 🕅 Yes 2 🗌 No		13. Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Spe an, Mexican, Puerto I	cify Yes or No- Rican, etc.)	14. Race - A Black, W	merican Indian, /hite, etc.
ours af tral", or Exami	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1952	1 ☐ Yes 2 💢 No	Specify:		Specify:	White
n 72 h "natu edical	Completed	15. Decedent's (Specify only highest of		16a	. Decedent's Usual Occup (Give kind of work done life. DO NOT use retired	during most of workir	ng	16b. Kind of Busine	ss/Industry
within iene.	dmo	Elementary/Secondary (0-12)	College (1-4or 5+	)	Barber	*/		Barber S	Shop
e filed al Hyg othe vent,	BeC	17. Father's Name (First, Middle, La	st)			18. Mother's Name	(First, Middle,		<u> </u>
ould b Menta arked	ToE	Warren	Leste	r 	Kegg	Mary	R	ebecca	Shunk
nd 2 shallth and 27 is m		19a. Informant's Name/Relationship Rosalie L. Kegg		I	o. Mailing Address (Street 11513 Valley				
of Heal		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	□Removal from State	20b. Place o	of Disposition (Name of ery, crematory or other place	ce) D	ate	20c. Location - City	or Town, State
t. Pag rtment rtant:		4 Donation 5 Dother (Spec	cify)	Sunse	t Memorial F			Cumberla	,
Depa Impo any to		21. Signature of Funeral Service Lic	S Uda	ros	1			rland, MI	1 Home, P.A. 21502
NA.		23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused t ly one cause on each line	he death. Do	not enter the mode of dyir	ng, such as cardiac o	r respiratory ar	rest,	Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. CONGEST		RT FAILURE				10 YEARS
Examiner	Examiner	Sequentially list conditions.	b. =						
uted		Sequentially list conditions, if any, leading to immediate cause. Enter Uncerlying Cause (Disease or injury that initiated events	Due to (or as a	consequence	of):				
e exection and and and and and	Еха	resulting in death) Last	C. Due to (or as a	consequence	of):				
tificate be executed ig physician and as the burial-transit	edical		d						
		IF FEMALE: 23b. Was decedent pregnent	23c. If yes, outcome p		n 3⊟Ectopic pregnanc			23d. Date of	delivery
The law requires that the death ce ate has been signed by the attendir page 2 should be detached for use	Physician/N	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at t		5 Other (specify)	,		Month	Day Year
w requires that been signed b should be deta	by Pi	Part II. Other significant conditions	-	_		en in Part I.	23e. Did to		e to the cause of death?
requir	eted	CHRONIC OBSTRUC	TIVE PULMONA	ARY DIS	SEASE		120		Probably 4 Unknown
<b>sician:</b> The law certificate has t irector, page 2 s	Completed	CHRONIC RENAL F	AILURE		<u></u>		24a. Was autop perfo	osy prior rmed! deat	e autopsy findings available to completion of cause of h? Yes 2 \( \sum \) No
ysician: is certifica director, I	Be C	25. Was case referred to medical examiner?				26. Place of Death			
Physical this cral direct	P.	1 ☐ Yes 2 💢 No 27. Mayner of Death	Hospital: 1 Inpatien		·	4   Nursing Hor		dence 6 Other (	Specify)
nding Ph th. ; After thi funeral	tion	1 X Natural 5 ☐ Pending Accident investigat	(Month, Day		Injury Wor	rk? Yes 2∐No	zod. Describe i	low injury occurred	
or Attendl ter death. Ilrector: A n by the fu	Certification:	3 Suicide 6 Could not 4 Homicide determine			arm, street, factory, office	- 2	28f. Location (5 City or Tox		r Rural Route Number,
pltal o		29a. Certifier 1 Certifying	Physician: To the hest of	f my knowledo	e, death occurred at the ti	me date and place	and due to the	cause(s) and manns	r as stated
To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	Medical			examination a	nd/or investigation, in my				
To the transfer of the transfer of the transfer of the transfer of	Σ	29b. Signature and title of certifier	0		29c. Licens			29d. Date signed (M	
5+		•	yw			33280		Uct!,	2008
MRS		30. Name and address of person w	M.D., 625	KENT AV	VENUE, SUITE	101, CUM	BERLAND	, MD 2150	2
Sta Registi		31. Date filed (Month, Day, Year) 0 2 2	37 Registral	r's Signature	Sporte				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State of Maryland / [ State Registrar		rtment of He			iene <sub>eg. No.</sub> 2	008	33531
J.			Decedent's Name (First, Middle, Last)				2. Date of Dea	th		3. Time of Death
*	Physicia		Lyman Judson Laughton	II	I		October	Day r 5	2008	10:17 P <sup>M</sup>
	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or L	ocation of Death		4c. Co	ounty of Death	
		-4-	604 Walnut Avenue		Rose Ha				ne Aru	
	Funeral		5. Social Security Number  6. Sex  7. Age (In yrs. last bit)	rthday)_ Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day 01-31-1	Year)	9. Birth	place (State or Foreign Intry) D.C.
A	Director		578-42-9499 94 Usual Residence of Decedent	113.			01-21-1	914	wası	г., р.с.
	/land ow at		10a. State 10b. County 10c. City, Tow	n or Loc	ation					10d. Inside City Limits
	a-f sh ified	io	MD Anne Arundel		Rose Ha	ven				1 ☐ Yes 2 No
	th the or 28,	Director	10e. Street and Number		10f. Zip Code		1	0g. Citizer	n of What Cou	untry?
	ath wi		604 Walnut Avenue		20714				SA	
	er dea	Funeral	11. Marital Status  12. Was Decedent Ever in U.S.  Armed Forces?	13. W	/as Decedent of Hisp Yes, specify Cuban,	panic Origin? (Spe , Mexican, Puerto	cify Yes or No- Rican, etc.)	14.	Race - Amer Black, White	
36	rs afte	by F	1 □ Never Married 2 □ Married  1 ☑ Yes 2 □ No II Yes, Give Year or Dates: 1936–42	1	□Yes 2∏ No	Specify:		S	pecify:	: t- a
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at	ba	15. Decedent's Education 16a		ent's Usual Occupati			16b. Kind	of Business/I	<u>ite</u> ndustry
215	hin 72 In "na Media	plet	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give k life. D	kind of work done dua O NOT use retired)	ring most of worki	ng			
21	d with	E C	5+ te	each	er and ad			*	ic sch	001
nd	be file tal Hy d oth	Be Completed	17. Father's Name (First, Middle, Last)		1	8. Mother's Name	, , ,		,	
yla	ould I	ဥ	Lyman Judson Laughton, Jr					Dun1e		
Maryland	12 sh h and 7 is m traum				Address (Street an					ip Code)
e, l	1 and Healt em 2		20a Method of Disposition 20b. Place of	of Dispos	alnut Ave		e Haven		20 / 1 4 tion - City or 3	Fown. State
nor	ages ant of t: If it		1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State	-	natory or other place)	i	2000	D	D	L TPT
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at one.		21. Signature of Funeral Service Licensee		Mem. Park Name and Address		3-2008   ausch Fi			
Ba	Depa Impo any I		William R. Clon	8	325 Mt. Ha					
ř.			23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.							Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	000						Onset and Death
200	/Medical		resulting in death)  a. Due to (or as a consequence	of):						MANTHA
è	Examiner		Sequentially list conditions b							
	Sit 9d	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	of):						
	cate be executed physician and the burial-transit	xam	Cause (Disease or injury that initiated events c	of):						
8760,	be exician			,-						
687	ficate physis the	edic	d							
Box	death certificate be executed e attending physician and d for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy	. a 🗆	Estacia escapación			230	d. Date of deli	very
	death e atte	icia	in the past 12 months?  1		Ectopic pregnancy Other (specify)				Month	Day Year
P.0	w requires that the d been signed by the should be detached	hys	9 Li Unknown				T			
	es tha igned be de		Part II. Other significant conditions contributing to death but not resulting i	in the un	derlying cause given	in Part I.				the cause of death?
ord	requir een s nould	ted	COPD; Siabeles; Hyper	ten	rion		1 D Y	es 2	No 3∏ Pro	obably 4 Unknown
Sec	S C	Completed by					24a. Was a autop	sy	prior to c	topsy findings available completion of cause of
a E	10 0						perfor 1□ Yes	2 No	death? 1 ☐ Yes	2 No
Division or Vital Records,	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?  Hospital: Hospital:		Othor	26. Place of Death	2.00			
ō	Physeral di	: To		Time of	28c. Injury a	4 LI Nursing Ho	me 5 Resid 28d. Describe h		☐Other (Spec	cify)
ion	Attending F r death. sctor: After by the funera	ition	Matural 5 □ Pending (Month, Day Year)  Accident investigation	Injury		es 2 No				
Visi	or Attendatter death	lica	3 Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of injury - At home, fit building, etc. (Specify)	arm, stre	et, factory, office		28f. Location (S City or Tow	treet and I	Number or Ru	ral Route Number,
Ö	tal or s afte al Dir	Certification:	4 I formade Building, etc. (Specify)				Ony or row	n, olale)		
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,		29a. Certifier (Check only Medical Examiner: On the basis of examination a	ge, death	occurred at the time	e, date and place,	and due to the o	cause(s) a	nd manner as	stated.
	the H hin 24 the F nplete	Medical	one) and manner stated.							
	with Cor	2	29b. Signature and title of certifier		29c. License				signed (Mo <i>ntl</i> -6-08	
			color Jeneger "	/1000		823		10	600	
10	W 10+1		30. Name and address of person who completed cause of death (Item 23a) Robert J. Schlager, M.D., 8924 Ch			North	Rosch	MD 2	7714	
W.	Sta	ite	31. Date filed (Month, Day, Year) 32. Registrar Signature			, NOI LII	Deacii,	עניז עניז	3/14	
	Registr		OCT 7 2008 Breus	S.	Coarte					
DH	IMH 17 Rev 1/2	001								

		FOI	epartment of Health and M	, ,	the state of the	33532
10 10 11		Registrar  1. Decedent's Name (First, Middle, Last)	Certificate of Death	2. Date of Dea	leg. No. 2008	3. Time of Death
Physic	ian			Month	Day Year	
/Medi Exami		Bessie B. Lewis  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	Septemb	oer 29, 200 4c. County of Dea	
LAGIIII		Future Care Pineview Nursing Home	Clinton		Prince G	eorge's
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	nday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day	9 Bir	Ihplace (State or Foreign
Director		5/7-26-2033	rs. Mondo Bays Floats Ivini.	6-25-19		derson, NC
land		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town	or Location			10d. Inside City Limits
Mary -f sho	호	MD Prince George's Accoked	k			1 ∐Yes 2 <b>X</b> No
h the r 28a	Director	10e. Street and Number	10f. Zip Code	1	log. Citizen of What Co	ountry?
th wit 23a c	al	16700 Holly Way	20607	υ	Inited Stat	es
er dea tems	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	<ol> <li>Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto F</li> </ol>	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
s afte	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 五 No If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:		Specify:	Black
tural", cal Exag	edk	15. Decedent's Education 16a. I	Decedent's Usual Occupation		16b. Kind of Business	/Industry
hin 72 an "ne Medic	plet	(Specify only highest grade completed)	'Give kind of work done during most of workir life. DO NOT use retired)	ng		•
d with	Completed		nager		D.C. Publi	c_Schools
d be file antal Hy ed oth	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name	, , , , , , , , , , , , , , , , , , , ,	Maiden Surname)	
Via ould a marke	ြိ	Alfred Bullock	Annie (Un			
peritinioie, interpretation Z.I.Z.13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notifiled at once.			Mailing Address (Street and Number or Rura 5700 Holly Way Acc		r, City or Town, State, . ID 20607	Zip Code)
T and 1 and Healt em 2					20c. Location - City or	Town, State
Deficiency  Department of mportant: If it any injury or once.		I LA Dunai 2 Li Cremation 3 Li Removal nom State	Disposition (Name of crematory or other place)  ncoln Cemetery 10/6/		·	
nit. F lartme ortan Injur	1 8	21. Signature of Fungral Service of ensee	22. Name and Address of Facility For			
Departiment of the post of the		Luchat throng	3401 Bladensburg R			
		23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.	ot enter the mode of dying, such as cardiac o	r respiratory arr	rest,	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition Cardiopulmunary				Onset and Death
/Medical		resulting in death)  Due to (or as a consequence of	r):			
Examiner	L.	Sequentially list conditions, if any, leading to immediate b. Hypertension  Due to (or as a consequence o				
ed sit	ine	if any, leading to immediate cause. Enter underlying Cause (Disease or injury	1):			
xecul and	Examiner	that initiated events resulting in death) Last	f);			-
of oU, cate be executed bhysician and the burial-transit	dica!					
g phy as the	edic	0.				
Leath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 1☐ Live birth 2☐ Fetal death	3 □Ectopic pregnancy		23d. Date of de	
deat deatt	sicis	1 Yes 2 No 4 Pregnant at time of death	5 Other (specify)		Month	Day Year
w requires that the de been signed by the should be detached	Phy	9 Li Unknown	the conduction of the Board	00- Bida-		
requires the	by	Part II. Other significant conditions contributing to death but not resulting in Stroke	the underlying cause given in Part I.		bacco use contribute t es 2 □ No 3 □ P	robably 4XJUnknown
requ peen s	Completed			4		
has by	ld m			24a. Was a	sv prior to	utopsy findings available completion of cause of
n: The ficate of, page	ပ္ပိ	25. Was case referred to medical			2X No 1 ☐ Yes	2 □ No
/sicia s certi	o B	examiner?	26. Place of Death  Other: 4 ▼ Nursing Hon		ne) ence 6 □Other <i>(Spe</i>	noiful
g Phy er thi	-	27. Manner of Death 28a. Date of Injury 28b. Ti	me of 28c. Injury at 2		ow injury occurred	city)
ath.	Certification:	2 Accident investigation	lury Work? M 1 ☐ Yes 2 ☐ No			
r Atte	tific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury · At home, farm building, etc. (Specify)	m, street, factory, office 2	28f. Location (S. City or Town	treet and Number or R n, State)	ural Route Number,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely illied in by the funeral director, page 2 should be detached for use as the burial-transit	Cer					
Hosp 24 hot Fune tely fi	ledical	29a. Certifier 1 ☐ Certifying Physician: To the best of my knowledge, (Check only one) 2 ☐ Medicat Examiner: On the basis of examination and and manner stated.	death occurred at the time, date and place, a for investigation, in my opinion, death occurre	and due to the o ed at the time, o	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
o the ithin 2 or the or	Med	one) and manner stated.  29b. Signature and title of certifier	29c. License number	1 9	29d. Date signed (Mon	th. Day. Year)
⊢≯≓४		· Married )	D51520		10-02-3	
0 5		30. Name and address of person who completed cause of death (Item 23a) (T				7779
1			thern Ave. SE #130 W	ashingt	on, DC 200	32
Sta	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature				

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hydiene

	ı	For State Registrar	State of Marylan		rtificate of L				08 33533	
Physici /Medic		1. Decedent's Name <i>(First, Middle, Last)</i> Mary	Lyons				2. Date of Dea Month Sept. 2.	Day	Year 3. Time of Death 10:30 a M	
Examin		4a. Facility Name (If not institution, give: Holy Cross Hospit	,			Spring		4c. County of		
Funeral Director		5. Social Security Number 6. Set 1 C	7. Age (In yrs. 90	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da 02/10/1	h y, Year) 1918	9. Birthplace (State or Foreign Country) North Carolina	
Maryland -f show ied at	tor	10a. State 10b. County  D • C •		y, Town or Lo					10d. Inside City Limits 1 AYes 2 No	
h with the 3a or 28a st be notii	Funeral Director	10e. Street and Number 4254 Fourth Stree	t, S. E. #20	1	10f. Zip Code 20032			10g. Citizen of W	hat Country? • A•	
ges 1 and 2 should be filed within 72 hours after death with the Maryland ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Middel Eximiner must be notified at	by	11. Marital Status  1    Never Married 2   Married 3   Widowed 4   Divorced	12. Was Decedent Ever in U. Armed Forces? 1		Vas Decedent of Hi fYes, specify Cuba I∐Yes 2 <b>X</b> ∑No	spanic Origin? (S n, Mexican, Puerto Specify:	pecify Yes or No o Rican, etc.)	1	- American Indian, k, White, etc. Black	
d within 72 ho giene. Ir than "natur	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 4th	cation e completed) College (1-4or 5+)	(Give life. L	dent's Usual Occupa kind of work done d DO NOT use retired, memaker	luring most of wor	king	16b. Kind of Bus	siness/Industry -Employed	
a y all of the first should be filed within and Mental Hygiene. is marked other than aumatic event, the Manauric event, the Ma	To Be C	17. Father's Name (First, Middle, Last) Unknown				18. Mother's Nam		Maiden Surname	9)	
and 2 sho ealth and n 27 is me		19a. Informant's Name/Relationship (Ty Donna Ballentine	pe. Print) (Granddaught		g Address (Street a			#201 C: 2003	2	
permit. Pages 1 and 2: Department of Health a Important: If item 27 is any injury or other trau		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☒ F 4 ☐ Donation 5 ☐ Other (Specify)		emetery, cren	sition (Name of natory or other place ake Crema	tory 10/	Date 02.2008	20c. Location - 0	City or Town, State	
permit Depart Import any inj		21. Signature of Funeral Service Licens	Baccon	W 32	Name and Addres H Baco 1447 14th	s of Facility n Funera Street,	1 Home N. W. Wa	I <b>nc.</b> ishingtor	n, D.C. 20010	
Physician		23a. Part1. Enter the disease, or complishock, or heart failure. List only or immediate Cause (Final disease or condition resulting in death)	cations that caused the death ne cause on each line. Sepsis	n. Do not ent	er the mode of dying	g, such as cardiac	or respiratory a	rrest,	Approximate Interval Between Onset and Death	
/Medical Examiner	je.		Due to (or as a consequence).  Due to (or as a consequence)							
fficate be executed physician and is the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause there underlying that initiated events resulting in death) Last	Due to (or as a consequent							
The law requires that the death certificate has been signed by the attending plage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 5 □ Other (specify) 9 □ Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Severe Cardio—Myopathy						23d. Date Mor	e of delivery hth Day Year	
quires that n signed t	by							23e. Did tobacco use contribute to the cause of death  1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown		
ician: The law requir certificate has been s rector, page 2 should	Completed							4a. Was an autopsy performed?  □ Yes 2√√2 No 24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2√√2 No		
hysician:	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	lospital: 1 🎽 Inpatient 2 🗆	FB/Outnatier	ot 3 🗆 DOA Othe	26. Place of Dea		<i>ne)</i> dence 6 □Othe	er (Snacify)	
e	<del>1</del>	27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury Work			how injury occurre		
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fun	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specif		eet, factory, office		28f. Location ( City or Tov		er or Rural Route Number,	
he Hospi in 24 hou he Funer pletely fill	edical		sician: To the best of my kno ner: On the basis of examina and manner stated.							
T with	M	29b. Signature and title of certifier	E, MA		D006			Sept. 27	(Month, Day, Year) 7  , 2008	
6		30. Name and address of person who co Irina Ruban, M.D				ilver Sp	ring, Md	1. 20917		
Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture						

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene

			For State Of Maryland / Departme	ate of Death		Reg. No. 2	3 33531
	Dhysiair		1. Decedent's Name (First, Middle, Last)	-	2. Date of Dea	th Day Year	3. Time of Death
Physician /Medical			James Edwin Morgan	0ctober	11 2008	1218 P <sup>M</sup>	
	Examin	er		ty, Town, or Location of Deat	h	4c. County of Dea	
and .				Boonsboro der 1 Year   If Under 24 Hrs	8. Date of Birt	Washing	gton rthplace (State or Foreign
	Funeral Director		219-42-5449 1 M 2 F 63 Yrs. Months Usual Residence of Decedent	S Days Hours Min.	8. Date of Birt (Month, Da) DEC 16,	v, Year) C	ountry) st Virginia
	/land		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	a-f sh	ctor	Maryland Cecil Elkton				1 □Yes 2¶ No
	or 28	Director		Zip Code		10g. Citizen of What C	ountry?
	ath w	ral	130 Carters Mill Road	21921		United S	
	er de Items	Funeral		cedent of Hispanic Origin? (\$ pecify Cuban, Mexican, Puer	specify Yes or No- to Rican, etc.)	14. Race - Am Black, Whi	
36	irs aft	þ	1 ☐ Never Married 2 M Married 1 ☐ Yes 2 M No If Yes, Give 1 ☐ Yes Widowed 4 ☐ Divorced Year or Dates:	2  No Specify:		Specify: WI	nite
ŏ	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show ant, the Medical Examination at benedified at	Completed	15 Decedent's Education 16a, Decedent's Us	sual Occupation	rking	16b. Kind of Business	
2	thin 7 ne. nan "r	nple	Flementary/Secondary (0-12)   College (1-4or 5+)	work done during most of wo use retired)	iking	<b>01</b> .	7
2	e filed within the Hygiene.  other than sent, the My			cal Operator	/Firek Adidale	Chemica Maiden Surname)	31
and	ev ev	Be	17. Father's Name (First, Middle, Last)			,	
Ž	d 2 should th and Men 7 is marke traumatic	유	William G. Morgan  19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Addre	ess (Street and Number or R	ebecca Di		Zip Code)
<u>8</u>	7 is 7			ters Mill Roa		-	
ē,	- I = =		20a. Method of Disposition 20b. Place of Disposition (N	lame of	ber 15,	20c. Location - City of	
Ē	. Pages tment of tant: If it		4 Donation 5 Other (Specify)  Union Cemete:	ry 2008		Union, MD	
Baltimore, Maryland 21215-0036	permit. Pages Department of Important: If it any injury or once.	1 18	21. Signature of Funeral Service Licensee  22. Name Hicks 103 W	and Address of Facility Home for Fun Stockton St	erals, P	.A. kton. MD	21921
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the m shock, or heart failure. List only one cause on each line.	node of dying, such as cardia	c or respiratory ar	rest,	Approximate Interval Between
in.	Physician	i	Immediate Cause (Final disease or condition	Lisala Dige	ene		Onset and Death
d	/Medical Examiner		resulting in death)  Due to (or as a consequence of):				
	LAAIIIIICI	<u>.</u>	Sequentially list conditions,  b. Due to for as a consequence of the conditions of t				
١.	uted I nsit	nine	Sequentially list conditions, if any, earning with restaurance of processes. Enter Underlying Cause. Enter Underlying Cause (Disease or injury that initiated events c.				
o,	execuin and ial-tra	Examiner	that initiated events resulting in death) Last				
68760,	rtificate be executed ng physician and as the burial-transit	edical	d				
89			IF FEMALE:				
Box	eath cer attendin for use	ian/	23b. Was decedent pregnant in the past 12 months?	c pregnancy		23d. Date of de Month	elivery Day Year
o.	The law requires that the death ce ate has been signed by the attendi bage 2 should be detached for use	Physician/N	1   Yes 2   No 9   Unknown	(specify)			
o,	that ned b		Part II. Other significant conditions contributing to death but not resulting in the underlying	g cause given in Part I.	23e. Did to	obacco use contribute	to the cause of death?
Records,	w requires that the de been signed by the should be detached	ed by	Diaster Mellitus		1 🗆 \	res 2 □ No 3 □ F	Probably Unknown
ပ္ပ	e law re has bee je 2 sho	Completed			24a. Was	an 24b. Were a	autopsy findings available completion of cause of
	sician: The la certificate ha rector, page?	Com			perfo	rmed?   death?	s 2 \( \text{No} \)
Vital	cian; ertific ector,	Be (	25. Was case referred to medical examiner?		ath (Check only o	ne)	Appropriate on biod
	Attending Physician: or death. ector: After this certification by the funeral director; p	မ	Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3	<del> </del>	T		ecity) C. Reno Mannt Rel
Division of	ding I	ion	27. Manner of Death  1 Manual 5 Pending (Month, Day, Year)  28b. Time of Injury  (Month, Day, Year)	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe i	now injury occurred	
Si	2 2 2 2	ficat	3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, fact		28f. Location (5	Street and Number or F	Rural Route Number,
2	al or / s after I Dire	Certification:	4 Homicide determined building, etc. (Specify)		City or Tov	vn, State)	
	lospita hours unera ly fille		29a. Certifier  (Check only (Medical Examiner: On the basis of examination and/or investigation)	red at the time, date and plac	ce, and due to the	cause(s) and manner date and place, and du	as stated.
	To the Hospital or Atter within 24 hours after de To the Funeral Directo completely filled in by th	Medical	one) and manner stated.	29c. License number		29d. Date signed (Mor	
	₹.¥ ₹. 8		NAXIA S			B.1 3	200 8
	^		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	Dousbabs		UC+ 15	200 0
	12		Stell Vot L mo 251 E. Antolin	St. How.t	soura 1	MO 21796	/
	Sta		31. Date files (Mooth Day, Year) 32. Registrar's Signature	., 0			
	Registr	ar	The state of the s				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Day **Physician** 4:30 P.M Michael Francis Myer 2008 15 October /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Towson Gilchrist Hospice If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 6. Sex Days 1**X** M 2□ F June 21, 1957 Director 212-76-5104 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County ral", or items 23a or 28a-f show Examiner must be notified at 1 XYes 2 □ No Director MD Harford Aberdeen the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 21001 U.S.A. 643 Sadler Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status 1 ☑ Never Married 2 ☐ Married 5-0036 "natural", or If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: \$ 3 Widowed 4 Divorced White Completed traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 n and Mental Hygiene. 2121 College (1-4or 5+) Elementary/Secondary (0-12) Security Security 12 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) Be Phyllis Blanche Skipper Caleb Francis Myer, Jr. ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21001 Aberdeen, Maryland of Health 643 Sadler St. Phyllis Myer (Mother) Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of Important; If its any injury or o once. 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 10/17/08 4 ☐ Donation 5 ☐ Other (Specify) Ferris & Co. West Chester, PA 22. Name and Address of Facility
Tarring-Cargo Funeral Home, P.A.
Aberdeen, Maryland 21001-3399 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final GASTROINTESTINAL BLEEDING **Physician** HOURS disease or condition resulting in death) /Medical Examiner Gaquentiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner attending physician and for use as the burial-trans resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) ed by the a detached f 1 □Yes 2 □ No. 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📆 Unknown page 2 should 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? certificate has 1 ☐ Yes 2 ☐ No Physician: After this certific funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Stother (Specify) HOSPICE 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? or Attending 1 Natural
2 Accident 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐Yes 2 ☐ No investigation 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certific D64395 OCTOBER 15, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE, MD 21204 DOBERMAN, MO 6565 N CHAPLES ST, SMITE 209 DANIEUE 32. Registrar's Signature 31. Date filed (Month, Day, Year) Registrar

Myer

			For State Registrar	State of Mar			Health and Me		2220	22526
					Cer	tificate of			g. No. / UUS	<u> </u>
	Physicia /Medic		1. Decedent's Name (First, Middle Shirley	Missouri				2. Date of Death Month Septembe	Day Year	3. Time of Death
4.0	Examin		4a. Facility Name (If not institution	n, give street and number)		4b. City, Town,	or Location of Death		4c. County of Death	1
· ·			Manor Care Nur				r Marlboro	150	Prince (	
	Funeral		5. Social Security Number 577–58–2483	6. Sex 7. Age 1	(In yrs. last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	3. Date of Birth (Month, Day, )	Year) Cou	nplace (State or Foreign untry)
	Director		Usual Residence of Decedent	6	66			April 6,	1942   Sout	h Carolina
	and		10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	be filed within 72 hours after death with the Maryland rital Hygiene. sd other than "natural", or items 23a or 23a-f show event, the Medical Examinat must be profiled at	Funeral Director	District of	Columbia	Washing		<u> </u>	10.	g. Citizen of What Cou	1 No 2 No
	vith th	Ö	10e. Street and Number 1101 - 46th S	treet NE		10f. Zip Code 200	19		United Sta	
	ath w	<u>ra</u>							14. Race - Amer	
	er de litem	in l	11. Marital Status	12. Was Decedent Ev Armed Forces?		f Yes, specify Cu	Hispanic Origin? (Spec ban, Mexican, Puerto R	ican, etc.)	Black, White	
21215-0036	ours after	ğ	1 ☐ Never Married 2 ☐ Mar 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give		1∐Yes 2∭ZNo				lack
5-	natu dicel	ete	15. Deceder (Specify only highe	nt's Education est grade completed)	(Give	dent's Usual Occu kind of work done	during most of working		6b. Kind of Business/I	ndustry
121	filed within Hygiene. ither than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+	)	DO NOT use retir	<sup>ea)</sup> Provider		Private	<b>.</b>
2	filed w Hygie other t		12 years	Last)	пеат	LII Care	18. Mother's Name	(First. Middle, Ma		
Maryland	ould be fi Mental H arked ot aric ever	Be	17. Father's Name (First, Middle, Allen Tate				Lillie N			
ž	s 1 and 2 should be f Health and Menta ttem 27 is marked other traumatic ev	은	19a. Informant's Name/Relations		10h Mailir	a Address (Stree	et and Number or Rural			(in Code)
Ma	d 2 sho th and 7 is me traume						Street NE V			
e,	s 1 and 2 of Health item 27 i		George Missou  20a. Method of Disposition	ri - Husband	20b. Place of Dispo				Oc. Location - City or	
Baltimore,	nit. Pages artment of ortant: If it Injury or c		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation _ 5 ☐ Other (\$	3 ☐ Removal from State  Specify)	Union Bap	t. Ch. C	emt. Oct.	4, 2008	Rembert,	SC
Balt	permit. Pages 1 Department of H Important: If ite any Injury or of once.		21. Signature of Funeral Survice	Licepsee	INA	2. Name and Add	ress of Facility Ste ing Road, I		neral Home ngton, DC	-
1	Physician		23a. Pat 1. Enter the disease, o shock or heart failure. List Immediate Cause (Final disease or condition	r complications that caused to tonly one cause on each line Sepsis	the death. Do not ente.	er the mode of d	ying, such as cardiac or	respiratory arres	st,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)		consequence of): Renal Fa	ilure				
		ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequence of):	2012				
777	uted d insit	듩	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Cerebro	ovascular .	Accident				
Ć,	execting and ial-tra	Examiner	resulting in death) Last	,	consequence of):					
8760,	icate be executed physician and s the burial-transit	ical		d. Diabete	es Mellitu	S 				
Box 68	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		⊒ Ectopic pregna	ncy		23d. Date of del	ivery Day Year
P.O. E	that the dea ned by the at detached fo	ysici	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4 ☐ Pregnant at 9 ☐ Unknown	time of death 5	Other (specify)			Nional	Day Tou.
	that the by detail		Part II. Other significant condit	ions contributing to death bu	t not resulting in the u	nderlying cause (	given in Part I.	23e. Did toba	acco use contribute to	the cause of death?
Records,	quires an sign uld be	Completed by	Hypertension					1 □ Yes	s 21∐ No 3 ☐ Pi	robably 4 🗆 Unknown
ပ္သ	aw requir s been s s should	Sete	Chronic Anemi	ia				24a. Was an autopsy		itopsy findings available completion of cause of
Ä	The law cate has page 2 s	E O						perform	ied? death?	2 No
Vital	iclan: The certificate ector, pag	Be C	25. Was case referred to medica	al			26. Place of Death			
f \	S S E	5 B	examiner? 1∐ Yes 2 ဩrNo	Hospital: 1 ☐ Inpatier	nt 2 ER/Outpatie	nt 3 □ DOA C	other: 43 Nursing Hon	ne 5 ☐ Resider	nce 6 □Other (Spe	cify)
on of	dlng J. After fune	tion:	27. Manner of Death  1 Natural 5 Pendi	28a. Date of Injur (Month, Day, tigation	y 28b. Time o (r, Year) Injury	l W	jury at 2 ork? □Yes 2 □No	8d. Describe how	w injury occurred	
Division	or Attending after death. Director: After in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could		ry - At home, farm, sti . <i>(Specify)</i>			8f. Location (Str. City or Town,	reet and Number or Ri , State)	ural Route Number,
	ospital or A hours after uneral Directly filled in by		200 Contilion 4 1 Constitution	ing Physician: To the best o	of my knowledge deal	th occurred at the	time date and place	and due to the co	ause(s) and manner a	s stated
	T 4 T 5	Medical	29a. Certifier 1 ☐ Certifyl (Check only one) 2 ☐ Medica	ing Physician: To the best of il Examiner: On the basis of and manner sta	examination and/or in	nvestigation, in m	y opinion, death occurre	ed at the time, da	ate and place, and due	e to the cause(s)
	To the I within 2 To the I complet	Ž	29b. Signature and title of certific	agents.			nse number	29	Octobor	•

State

31. Date filed (Month, Day, Year)
OCT 0 3 2008

Meklit Workneh, M.D.

30. Name address of person who completed cause of death (Item 23a) (Type, Print)

Meklit Workneh, M.D. 7705 Belle Point Drive Greenbelt, MD 20770

Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) MORSOLL : 46 A M 2008 10 4b. City, Town, or Location of Death 4c. County of Deatly 4a. Facility Name (If not institution, give street and number) NIA BALLIMORE BALLIMORE VA MEDICAL CONTER Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, 5. Social Security Number 6 Sex Days Hours Nov. II 58<sup>Yrs</sup> 214-56-2492 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 1 ☐ Yes 2 No Director Calvert **Owings** MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 20736 Funeral 806 W. Chesapeake Beach Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No | 969 If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2**X** No Specify: 2 3 ☐ Widowed 4 ☐ Divorced Black Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Self-employed Cement Finisher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be **Dorothy Washington** ၉ Joseph W. Morsell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 806 W. Chesapeake Beach Road, Owings, MD 20736 Helen Spriggs - Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 ☐Removal from State 4 Donation 5 Dother (Specify) 10/9/2008 Cheltenham Veterans Cem. Cheltenham, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Sewell Funeral Home, P.A., 1451 Dares Beach Rd., Prince Frederick, MD 20678 23a. Part1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Metastic carcinoma 5 MONTHS ot unknown primary

Examiner lical

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

"natural", or items 23a or 28a-f show idical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any Injury or other traumatic event, the Medical Examiner.

**Physician** /Medical Examiner

Baltimore, Maryland 21215-0036

death with the Maryland

Physician: The law requires that the death certificate be executed attending physician After this Hospital or Attending Director;

Division or Vital Records, P.O. Box 68760,

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n: To Be Completed by Physician/Med	-
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- 1	resulting in death)	a.	THE REAL PROPERTY.		1	7	
	Todaming in dodainy	Due to (or as a consec	juence of):		,	U	
	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b.  Due to (or as a consec	juence orj:				
IICai Eval	that initiated events resulting in death) Last	Due to (or as a consected.	juence of):				
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregn 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of o	al death 3 □Ectopic			23d. Date of de Month	elivery Day Year
ed by ri	Part II. Other significant conditions of	contributing to death but not res	sulting in the underlying	g cause given in Part I.			to the cause of death?
naidillo.					24a. Was an autopsy perform 1□ Yes 2	ed2 death?	autopsy findings available completion of cause of s 2 □ No
	25. Was case referred to medical examiner?			26. Place of De	eath Check onl one		
	1 ☐ Yes No	Hospital: 1 Inpatient 2	ER/Outpatient 3	DOA Other: 4 Nursing	Home 5 ☐ Resider	nce 6 Other (Sp.	ecify)
	27. Manner of Death  1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how	w injury occurred	
	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - At h building, etc. (Speci	ome, farm, street, factify)	ory, office	28f. Location (Streetly or Town,	eet and Number or F State)	Rural Route Number,
Medical Cellingation, 10		nysician: To the best of my kn miner: On the basis of examin and manner stated.					
M	29b. Signature and title of certifier			29c. License number	29	d. Date signed (Mor	nth, Day, Year)
	Jennie of	LAUT M.N.	l i	12252966	97 1	0/02/20	>0%

DHMH 17 Rev 1/2001

State

Registrar

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den 10

Greek Street BALLIMORE MD 21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

32. Registra Signature

Jennie

OCT

31. Date filed (Month, Day, Year)

D and

State Registrar 31. Date filed (Month, 2000)

Patricia Aronica-Pollak MD.



Assistant Medical Examiner

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

October 2, 2008

30. Name and address of person who completed cause of death (Item 23a)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Pauline Maria Pullen Morant October 1, 2008 6:30 P. <sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number)
Larkin Chase Rehabilitation and
Nursing Center 4b. City, Town, or Location of Death 4c. County of Death Examiner Bowie Prince Georges 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 1919 9. Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2**X** F 89 Director 223-12-1911 September 21, Virginia Usual Residence of Decedent a or 28a-f show t be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1**X** Yes 2 □ No Director Maryland Prince Georges Bowie 10f. Zip Code 10g. Citizen of What Country? ural", or items 23a o I Examiner must be 15005 Health Center Drive 20716 United States r death Funera 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No **Black** \$ Specify: 3 X Widowed 4 ☐ Divorced "natural" Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. United States Elementary/Secondary (0-12) College (1-4or 5+) Library Technician 4 years Library of Congress 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental H-Important: If item 27 Is marked oth any Injury or other traumatic event Be Alfred Pullen ပ Mary Alice (unknown) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kaye Ann Braxton(Adopted Daughter) 3703 Eton Way; Upper Marlboro, Maryland 20772 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Oct.10,2008 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State George Washington Cemetery 4 □ Donation 5 □ Other (Specify) Adelphi, P.G. Co. Maryland 2 signature of meral Service 27. Name and Address of Facility
28. N. Horton Company Morticians, Inc. 600 Kennedy Street, N.W.; Washington, D.C. 20011 23a. Part1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Adenocorcinoma **Physician** /Medical resulting in death) Due to (or as a consequence of) Examine Sequentially list conditions, if any, leading to imm. Leading to imm. Leading to imm. Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine death certificate be executed physician and is the burial-trans Due to (or as a consequence of) Physician/Medical as attending IF FEMALE use 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy for in the past 12 months? 1☐ Yes 2 X No Month 5 ☐ Other (specify) 4□Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2 R No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy pertormed? 1 ☐ Yes 2 ☐ No 2**X** No 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 Tes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No hours after death 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide

Division or Vital Records, P.O. Box 68760. Hospital or Attending

Maryland 21215-0036

Baltimore,

State Registrar

24 hours a

within 24

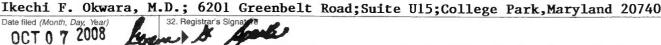
completely

31. Date filed (Month, Day, Year) OCT 0 7 2008

29b. Signature and title of certific

(Check only one)

2 Medical E



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

aminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

October 0

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar		State o	f Marylar		artmer <i>rtifica</i> :			and M	ental Hyوا ا	giene Reg. No.		2 22	51.0	
Н	Physicia		1. Decedent's Name (		,							2. Date of Dea Month October 3	ath Day	79 Yea	3. Time 5:16	of Death	
	/Medic		4a. Facility Name (If no	ot institution, giv	ve street and nu	mber)	· · · · ·	4b. City,	Town, or	Location of			_	County of De	ath		
			Washingto	on Advent:	ist Hospi	tal		-	koma 1					Montgom	ery		
	Funeral Director		5. Social Security Num 579–34–4439		Sex 1 □ M 2 🙀 F	7. Age (In yrs.	last birthday) Bl Yrs.	If Unde Months	1 Year Days	If Under: Hours	24 Hrs. Min.	8. Date of Birt Month, Da March 30,	1927	9. B	irthplace (State Country) Laware	e or Foreign	
and	M		Usual Residence of De 10a. State 1	ecedent 0b. County		10c. Cit	ty, Town or Lo	cation							10d. Inside City Limits		
Maryl	-f sho	ō	Maryland	Montgor	nery		ilver Sp									es 2 No	
the .	r 28a	Director	10e. Street and Number	er				10f. Zip	Code				10g. Citi	zen of What (	Country?		
th wit	23a o		3903 Ilfo	ord Road				20	906				US	SA.			
5-UU36 72 hours after death with the Maryland	nt of Health and Mental Hygiene. If item 27 Is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Modical Examiner must be notified at	by Funeral	11. Marital Status  1 Never Married  3 Widowed 4		12. Was Dece Armed Fo 1 ∐Yes If Yes, Gi Year or D	2 ₩ No ve ₩		If Yes, specify Cuban, Mexican, Puerto Rican, etc.)						Black, Wh			
215-UL hin 72 hou	e. an "natura Medical E	Completed	15	5. Decedent's E	ducation		16a. Dece (Give life, i		rk done d	lurina most	t of worki	ing	16b. Ki	White (ind of Business/Industry			
Z I	ygiene er tha t, the	Con		.2	- Conogo (		Home	maker					Ow	n Home			
aryland 2121 should be filed within	fental H	To Be	17. Father's Name (Fit George Vas								er's Name ella V	e (First, Middle, Valko	Maiden	Surname)			
S 2	lealth and Menta m 27 Is marked oner traumatic ev		19a. Informant's Name	e/Relationship (			1	9	,			al Route Numbert, Harpe:			,	-	
More,	Department of Heal Important: If item 2 any injury or other once.		20a. Method of Dispos	Cremation 3		State	Place of Dispo cemetery, cren	sition (Nai	ne of ther place	9) C	ctobe	Date	20c. Lo	cation - City o	r Town, State		
altin mit. Pe	Departme Important any injury once.		4 ☐ Donation 5			Par		. Name ar	d Addres	s of Facility				ville, N	1D		
n 8	8 5 8		Thu	8	Scent	7	50	ancıs O Univ	ersit	y Blvo	Fune:	ral Home : Silver S	Inc. oring	, MD 209	901		
	ysician		23a. Par Enter the shock, or hear Immediate Cause (Fir disease or condition resulting in death)	ailure. List only	plications that cone cause on e	aused the deat ach line.	h. Do not ent	er the mod	le of dyin	g, such as	cardiac (	or respiratory ar	rest,		Approxim Interval B Onset an	ate detween d Death	
	Medical aminer		Sequentially list condit	tions	b. Acc	or as a conseq	uence of): NURIC	R	ENA	L FI	4/14	YE			DAY	15	
cuted	nd ransit	Examiner	cause. Enter Underlyi Cause (Disease or injuthat initiated events	uence of,. NSION	1_K				INOTE	OPE	<del>-</del> S	wer	KS				
o / oU, cate be executed	physician and s the burial-transit	dical Ex	resulting in death) Las	st .		of as a conseq F7U S	vence of): Post	Co	20N F			YPASS			WEE	75	
DIVISION OF VIGAL RECORDS, F.O. BOX OF the Hospital Asharding Physician: The law requires that the death certific	attending for use a	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)									23d. Date of delivery  Month Day Year			Year		
v requires that	signed by	þ	Part II. Other significa	ant conditions	contributing to de	eath but not res		nderlying o	-	n in Part 1.			bacco u		to the cause o		
he law req	tean.  for: After this certificate has been signed by the the funeral director, page 2 should be detached	Completed	CLOSTR	Drain	DIFFI	EILE						24a. Was a autop	sy med?_	prior to death?		s available f cause of	
an:	tificat or, pa	ပိ	25. Was case referred	to medical						26 Place	of Death	1 □Yes		1 □ Ye	s 2□No		
lysici	iis cer direct	70 B	examiner? 1 ☐ Yes 2 🗹 No	)	Hospital: 1	npatient 2	ER/Outpatien	nt 3 □ D0	Othe			me 5 Resid		0 □ Other (St	ecify)		
nding Ph	an. r: After th e funeral	ation: T	27. Manner of Death 1 ☑ Natural 2 ☐ Accident	5 □ Pending investigation		of Injury th, Day, Year)	28b. Time of Injury	M 2	8c. Injury Work			28d. Describe h					
al or Atte	2 6 6	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, factory, offi building, etc. (Specify)									28f. Location <i>(S</i> City or Tow			Rural Route No	ımber,	
e Hospit	winin z4 nours arter deam.  To the Funeral Director: After this completely filled in by the funeral di	edical (	29a. Certifier 1 (Check only one) 2	Certifying Ph	niner: On the b	best of my kno asis of examina ner stated.	wledge, death tion and/or in	occurred vestigation	at the tim , in my op	ne, date an pinion, dea	nd place, th occurr	and due to the red at the time, or	cause(s) date and	and manner place, and d	as stated. Je to the cause	<b>∂</b> (s)	
To th	To th	Me	29b. Signature and title	e of certifier				1	. License			- 2	29d. Dat	e signed (Mo	nth, Day, Year)		
6	,		1/lun	while	2			D36207 October 3,200				38					
			30. Name and address					Print)						- ·	,		
D				as C. Mil		0 Carrol] egistrar's Signa		, #440	'Tak	oma Pa:	rk, M	D 20912					
	Stat Registra	-	31. Date filed (Month,	1 AK 1	108	egistial s olyfia	K So										

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			1 - State of State of Registrar	Maryland / Depa	artment of He			iene 200	8 33541	
	Dhyaiai		1. Decedent's Name (First, Middle, Last)				2. Date of Deat Month		3. Time of Death	
	Physici /Medio		Frederick	Mey				2008	9:45 A M	
	Examir	er	4a. Facility Name (If not institution, give street and num 6860 Tulip Hill Terrace	ber)	4b. City, Town, or Lo Bethesda	ocation of Death		4c. County of Dea		
	Funeral		•	. Age (In yrs. last birthday)		f Under 24 Hrs.	8. Date of Birth	Montgome	9	
	Director		081 <b>-</b> 22-1000 <sup>1</sup> X <sup>M 2□ F</sup>	79 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, $18$	<sup>Year)</sup> 1929	rthplace (State or Foreign ountry) New Jersey	
	put w		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	cation				10d. Inside City Limits	
	/aryla	o	MD Montgomery		caton				1 X Yes 2 □ No	
	the N	rect	10e. Street and Number	Bethesda	10f. Zip Code		1	0g. Citizen of What C	ountry?	
	h with 23a or	al D	6860 Tulip Hill Terrace		20816			United St	ates	
Maryland 21215-0036	be filed within 72 hours after death with the Maryland that Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Madical Execution or neat be rectified at	d by Funeral Director	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced  12. Was Deced Armed Force 1 ☑ Yes 2 1/ Yes, Give Year or Dat	No	Was Decedent of Hisp f Yes, specify Cuban, 1 □ Yes 2 🛣 No	panic Origin? (Spe Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)	14. Race - Am Black, Whi Specify: W		
5-0	72 h	letec	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupation kind of work done duri		ng	16b. Kind of Business	/Industry	
121	within iene. than "	Completed	Elementary/Secondary (0-12) College (1-4+	or 5+)	DO NOT use retired) Sician			Modical		
d 2	2 should be filed within and Mental Hygiene. is marked other than aumatic event, Ita M.	ပိ	17. Father's Name (First, Middle, Last)	litys		8. Mother's Name	(First, Middle, M	Medical Maiden Surname)		
lan	ould be f Mental arked o atic eve	To Be	Samuel Meyers			Estelle	Poznak			
lary	2 shou and N is man		19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	ng Address (Street and	d Number or Rura	l Route Number	; City or Town, State,	Zip Code)	
	es 1 and 2 of Health of Fitem 27 is r other tra		Phyllis O. Meyers - Wife		Tulip Hi					
altimore,	Part   Population   Populatio									
Balt	permit. Pages 1 Department of I Important: If ite any Injury or of		21. Signature of Funeral Service Licensee	Ęź	Name and Address a lward Sage 191 Rockvil	of Facility I Funera	l Direct	ion Inc	Sentation A.	
			23a. Part 1. Enter the disease, or complications that car shock, or heart failure. List only one cause on ear	used the eath. Do not ent	er the mode of dying,	such as cardiac o	r respiratory arre	est,	Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition	oronary Arter					Onset and Death  10 years	
	/Medical Examiner		Due to (o	ras a consequence of): Labetes					_	
		e.		r as a consequence of):					20 years	
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ó	e exec an an rial-tr	Exa	resulting in death) Last Due to (o	as a consequence of):						
8760,	icate be executed physician and the burial-transit	dical Examiner	d					<del></del> .		
O. Box 6	ath certifi	Physician/Med	in the nest 12 months?	nt at time of death 5	Ectopic pregnancy Other (specify)			23d. Date of do Month	elivery Day Year	
σ.	ires that the de signed by the a	Y Ph	Part II. Other significant conditions contributing to dea	th but not resulting in the ur	nderlying cause given i	in Part I.	23e. Did tob	pacco use contribute	to the cause of death?	
rds	quires en sigr uld be	ed by					1 □ Ye	es 2. XIVo 3. □F	robably 4 ☐ Unknown	
Records,	law as b 2 s	Completed					24a. Was ai		utopsy findings available completion of cause of	
B	ysician: The law lis certificate has b director, page 2 si	Som					perform	ned?   death?	s 2 🛛 No	
Vital	Physician: r this certific ral director, p	Be	25. Was case referred to medical examiner?			6. Place of Death	(Check only one	e)		
of	> .50 ₽	۲.		Datient 2 ☐ ER/Outpatien  Injury 28b. Time of		4 - 14d(3)(19 110)		ence 6 Other (Sp	ecify)	
on	Attending r death. sctor: After by the funer	tion	27. Manner of Death  1 ☒ Natural  2 ☐ Accident  28a. Date of (Month)  (Month)	Day, Year) Injury	Work?	s 2 □No	od. Describe no	w injury occurred		
ODivision of	I or Atter after dea Director I in by the	Certification: To	o □ Outside 6 □ Could not be	I f Injury - At home, farm, stre l, etc. <i>(Specify)</i>			18f. Location (St. City or Town	reet and Number or F a, State)	lural Route Number,	
Þ	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical C	29a. Certifier (Check only one)  (Check only one)  (Check only one)	sis of examination and/or in	n occurred at the time, vestigation, in my opin	, date and place, a lion, death occurre	and due to the cared at the time, da	ause(s) and manner a ate and place, and du	as stated. e to the cause(s)	
	To the within To the Sompl	Me	29b. Signature and itle of certifier		29c. License no			9d. Date signed (Mor		
	25		12m alinh		D14107		0	ctober 6,	2008	
	,		30. Name and address of person who completed cause Bryan J. Arling MD 2440	of death (Item 23a) (Type, I	Print) #817 Wash	ington D	C 20037			
H	Sta Registr	te ar	31. Date filed (Month, Day, Year)  OCT 0 7 2008	gistrar's Signature	É					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day Year Month Edward McCabe October 4, 2008 9:10 4c. County of Death 4a. Facility Name (If not institution, give street and number) Bethesda Montgomery Maplewood Park Place If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1√2 M 2□ F 578-42-3993 91 03/04/1917 Ireland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No MD Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9707 Old Georgetown Road #2507 United States 20814 12. Was Decedent Ever in U.S. Armed Forces?

1 Wes 2 No 1941- Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify. Specify: White 1945 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Law Practice Lawyer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alice McDonnell Patrick McCabe 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas McCabe / Son 566 Innsbruck Ave. Great Falls, Virginia 22066 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Gabriel's Cemet. 10/08/2008 Potomac, Maryland 22. Name and Address of Facility Joseph Gawler's Sons Inc. 21. Signature of Funeral Service License 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Seizures disease or condition resulting in death) Due to (or as a consequence of): Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Congestive Heart Failure 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed' 1 □Yes 2√ No 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No 27. Manner of Death 1 X Natural 2 ☐ Accident 5 Pending

**Physician** /Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed

Physician

Examiner

**Funeral** 

Director

ral", or items 23a or 28a-f show Examiner must be notified at

'natural", or

er than "nature the Medical E

f Health and Mental H tem 27 Is marked oth other traumatic even

Department of Health a Important: If item 27 Is any Injury or other trainonce.

Director

Funeral

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Completed

Be

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the Maryland

Pages 1 and 2 should be filed within 72 hours after death with

Baltimore, Maryland 21215-0036

/Medical

attending physician and for use as the burial-tran funeral director. nours after death. neral Director: Af illed in by the fur

Medical

3 🗌 Suicide

29a. Certifier

4 Homicide

(Check only

Examiner Be Completed by Physician/Medical Certification: To

signed by the a d be detached for certificate has b After this

←Division of Vital Records, P.O. Box 68760,

completely To the within 2 20

24 hours a

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No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 DO	OA Other: 45 Nursing H	ome 5 ☐ Residence 6 ☐ Other (Specify)
5 ☐ Pending investigation		28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred
6 ☐ Could not be determined		ome, farm, street, factory fy)	y, office	28f. Location (Street and Number or Rural Route Number City or Town, State)
1 Certifying Ph	ysician: To the best of my kno	wledge, death occurred	at the time, date and place	e, and due to the cause(s) and manner as stated.

D26259

9b. Signature and title of certifier	T
1 / St / d o o o o o o	1
· CHECKINI	+

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number

10/06/2008

30. Name and address of person who completed cause of dear Iltem 23a) (Type, Print)

Ava Kaufman MD 8218 Wisconsin Ave., #103 Bethesda, MD

State Registrar 31. Date filed (Month, Day, Year) 07 CT 2008



#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death Time of Death **Physician** Fave Markowitz Ottober Bay 2008 ar 1155 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** The Hebrew Home of Greater Washington Rockville Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🔀 F Hours **Director** 059-26-3604 July 6, 1932 Latvia Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mential Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event the Landers 10c. City, Town or Location 10b. County 10d. Inside City Limits MD Potomac Montgomery 1 Yes 2 No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12820 Three Sisters Road 20854 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married I ☐ Yes 2 X No f Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Completed by White 3 TWidowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jacob Pitem Rachel Dushowitz 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bruce Markowitz - Son 12820 Three Sisters Road Potomac MD 20854 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) New Montefiore Cem. 10/7/08 West Babylon, NY 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Edward Sagel Funeral Direction Inc 1091 RockVille Pike RockVille MD 20852 23a. Part1. Enter the discrete se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) umonio /Medical Due to (or as a consequence of) Examiner rementio Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ funeral director, page 2 should be Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performe 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 ☐ Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending within 24 hours after death. To the Funeral Director: A completely filled in by the fu death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29b. Signature and title of certifier 29c. License number

State Registrar

31. Date filed (Month, Day,

Year

7 2008

DHMH 17 Rev 1/2001

who completed cause of death (Item 23a) (Type, Print)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> 2008 **Physician** Petrona Maldonado October 3, 9:15 рм /Medical 4a. Facility Name (If not institution, give street and number, 4b. City. Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 219-90-7819 Months Days Hours Min 1 M 2 XF 93 January 31, 1915 Honduras **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Items 23a or 28a-f show ner must be notified at 1 □Yes 2X No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 321 University Blvd., Apt. 124 20901 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. 1 Tyes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 'natural', or 1. TXYes 2 □ No Specify: Honduran White Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business/Industry (Give kind of work done d life. DO NOT use retired) (Specify only highest grade completed) during most of working Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 27 is marked or traumatic ever Unknown Maldonado Juliana Gonzalez 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.9 Department of Health at Important: If item 27 is any injury or other trauonce. Mirtha Brown/Personal Rep. 10125 Ridgeline Drive, Montgomery Village, MD 20886 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State October 5, 1 ☐ Buria 2 Cremation 3 ☑ Removal from State Alexandria, Virginia Metropolitan Crematory 4 □ D6na 5 Other (Specify) 2008 21. Signatur 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd., W., Silver Spring,MD 20901 23a art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Respiratory Failure /Medical Due to (or as a consequence of) Sepsis **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter ordering Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine law requires that the death certificate be executed Pneumonia ysician and e burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical phys ; the i attending pl for use as t IF FEMALE: 23c. If yes, outcome pf pregnancy
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1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1□ Yes 20 No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 ☑ No မှ 1 🔀 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After (Month, Day Year) 1xXNatural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier 1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier d63343 October 4, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Road, Silver Spring, MD 20910 Irina Ruban, MD 31. Date filed (Month, Day, Year) 82. Registrar's Signature State Registrar

		State of Maryland / Department of F	Health and M	lental Hygi	ene	33545
		Registrar Certificate Of a	Death		g. No. 2 U U O	
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Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,		hplace (State or Foreign untry)
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12 sh thand 7 is n traun		19a. Informant's Name/Relationship (Type. Print)  Rosella F. Brode/ Sister  19b. Mailing Address (Street 5436 Dogwood				Zip Code)
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he Ho in 24 he Fu	edical	(Check only one)  Medical Examiner: On the basis of examination and/or investigation, in my one)  and manner stated.	opinion, death occur	red at the time, da	te and place, and due	to the cause(s)
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Soph	7	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	A A	MAPALIA	Wnzac	
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Registra	ar	OCT 0 3 2008 Figure D. Aparles				

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Physician		Immediate Cause disease or conditi- resulting in death)	ion	a. Chame	Obstano	the be	Dolmar	1 discor	- CXO	centy	extroin	Opset and Death
/ /Medical Examiner		resulting in death)		Due to (or as	a conseque	nce of):	Sen (	thick "				1 links now
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oe exection and cian and curial-tr	Exc	resulting in death)	Last	Due to (or as	a conseque	nce of):						
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To the Hospital or Attending Physiclan: The I within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical	29a. Certifier (Check only one)	1  Certifying P 2  Medical Exa	Physician: To the best aminer: On the basis of	of examinatio	edge, death n and/or in	occurred at the twestigation, in my	ime, date and place, opinion, death occur	and due to the red at the time	e cause(s , date and	and manner a d place, and due	s stated. e to the cause(s)
o the ithin 2 o the omple	Med	29b. Signature and	d title of certifier	and manner sta	ated.		29c. Licens	se number		29d. Da	te signed (Moni	th, Day, Year)
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6+		30. Name and add	iress of person who	completed cause of d	death (Item 2	3a) (Type, I		11000			30, 200	
nds		Shah	een I	abal, M	0 12	2821	Oak	Hu Ar	e. Ha	ages	stown.	m021742
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 21:37 9/27/2008 JAMES E. MEANS /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Laurel Regional Hospital PG Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min 10/13/1926 Lorado, WV 81 Director 235-32-3155 Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Mudical Examinar must be notified at 1 ☑ Yes 2 ☐ No Director Prince George's Laurel Marvland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20707 14810 Ashford Ct. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Bace - American Indian. 11. Marital Status Black, White, etc 1 X Yes 2 ☐ If Yes, Give Year or Dates: Specify: Black 1 ☐ Never Married 2 Married 2 No 1 ☐ Yes 2 🔀 No Specify þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 72 (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within th and Mental Hygiene. 7 is marked other than ". Elementary/Secondary (0-12) College (1-4or 5+) Private Industry Coal Miner 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Orlenas Mobley မ Joe Wheeler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) 14810 Ashford Ct. Laurel, Maryland 20707 Health Irene P. Means / Spouse 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Pages 1 Department of Important; If it any injury or concept of concept 1 ☐ Burial 2 ☐ Cremation 3 🖾 Removal from State Forest Lawn Cemetery 10/7/2008 Pecks Mill, W.Va. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Librare 22. Name and Address of FacilityPope Funeral Homes, P.A. 5538 Marlboro Pike Forestville, Maryland 20747 Lung MO1089 23a. Part 1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Immediate Cause (Final Aspiration Pneumonia Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Dehydration Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transi Anemia and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Fctopic pregnancy Day Month in the past 12 months? 5 ☐ Other (specify) signed by the a 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably ♣ Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I page 2 s autonsv performe 1 ☐Yes 2 XNo 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Be 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ∐ Yes 2 ZXNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 ☐ Pending investigation 1X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier 1 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760, Division of Vital Records, ours after death.
neral Director: Aft Hospital

Baltimore, Maryland 21215-0036

State

Registrar

29c. License number D0064760 29d. Date signed (Month, Day, Year)

September 29, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7300 Van Deusen Rd. Laurel, Md. Mythily Vancha, M.D.

31. Date filed (Month, Day, Year)

29b. Signature and title of certifler

(Check only one)

OCT 0 1 2008



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 12:25 PM Annabel Lee McCloskey 27, 2008 Sept. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 8. Date of Birth (Month, Day, Year) Prince George's Prince George's Hospital Cheverly If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 ☐ M 2 🛛 F 81 1927 212-24-4611 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 XYes 2 No notified Directo Maryland Prince George's Brentwood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be r 3814 37th Place 20722 USA Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 72 hours after 1 Never Married 2K Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No White Specify: þ 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other traumatic event, the Medical than Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed withi nent of Health and Mental Hygiene. ant; If item 27 Is marked other thar Police Officer Law Enforcement 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Edgar Boteler Hazel M. Talbot 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward J. McCloskey / Husband 3814 37th Place, Brentwood, MD 20722 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any Injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery 10/03/2008 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility 4739 Baltimore Avenue Hyattsville, MD 20781 danning Gasch's Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner mona Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): certificate be executed burial-transit Exam Due to (or as a consequence of) P.O. Box 68760 attending physician Physician/Medical as the IF FEMALE nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) detached 9☐Unknown 9 Unknown signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records. 1 | Yes 2 | No 3 | Probably 4 | Onknown cate has been signated by Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an performe 2 No Physician: 25. Was case referred to medical examiner?
1 ☑ Yes 2 ☐ No 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 28d. Describe how injury occurred Fell at 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Injury 5 ☐ Pending investigation 1 Natural Lone 1 Se. Place of injury - At home, farm, street, factory, office building, etc. (Specify) death. 1 Yes 2 No To the Hospital or Attendi within 24 hours effer death. To the Funeral Director: A 2 Accident the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number City or Town, State) 3814 37 Feb. filled in by 4 Homicide home 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated.

State Registrar

Gary Lamont Little, 3001 Hospital Drive, Cheverly, MD 20785 31. Date filed (Month, Day, Year) 32. Registrar's Signature

OCT 0 1 2008

29b. Signature and title of certifier

30. Name and address of person,

ho completed cause of death (Item 23a) (Type, Print)

29c. License number

D58957

29d. Date signed (Month, Day, Year)

09/30/2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month MCGLOTTEN 545A RONE 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE
If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. NOW OF MARYLAND MED CNTR Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F 321-48218 Director 1956 Usual Residence of Deceden Pages 1 and 2 should be filed within 72 hours atter death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Experient must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No **Funeral Director** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19956 010 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify <u>ک</u> Specify: 3 Widowed 4 Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Loth 004 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ neso 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda Hveet DE 19956 aurd 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of F
Important: If ite
any injury or ot
once. 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) aure 10 22. Name and Address of Facility Teabella St 21. Signature of Funeral 8 Smith MD ZIFOI or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, App oximate Interval Between Onset and Death 23a, Part 1. Enter the diseas shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician HEMOPTYSIS /Medical Due to (or as a consequence of): Examiner Mos CELL LUNG CANCER Sequentially list conditions, in any, reading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No his certificate has but director, page 2 st 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 **X**No 1 ☐ Yes 2 200 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred After Natural 5 ☐ Pending investigation ours after death.

leral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital of within 24 hours at To the Funeral D completely filled in 29a, Certifier 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

DHMH 17 Rev 1/2001

State

Registrar

30. Name and a

SAMES

Day, Year)

OCT 0 3 2008

31. Date filed (Month

**ORIGINAL** 

GREENE

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dress of person who completed cause of death (Item 23a) (Type, Print)

MD

egistrar's Signature

BACTIMORE MI)

08-07236 John Paul Niba Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

hn Paul Niba	1- For State	e of Maryland / Departr <i>Certifi</i>	cate of Death		eg. No. 201	08 3355
Physician/ ledical Examine		PAUL	NIBA	2. Date of Dea		3. Time of Death 1501 hrs
<i>y</i>	4a. Facility Name (if not institution, g	ive street and number)	4b. City, Town, or Loca Silver Spring		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 6.	Sex 7. Age (In yrs. last b	oirthday) If Under 1 Year If	Under 24Hrs. 8. Date of Bir Hours. Min. AUGUST	19/8 Co	rthplace (State or Foreign buntry) MEROON
ow any	Usual Residence of Decedent	GEORGE'S 10c. City, Tov	wn or Location			10d. Inside City Limits 1 XYes 2 No
ith the Maryland 23a or 28a-f show notified at once. al Director	10e. Street and Number 4436 STOCKBRIDG	E COURT	10f. Zip Code 2 0 7 2 0	1	0g. Citizen of What Cou	
Rer death wi		1 Yes 2 X No	If Yes, specify Cuban, Me	exican, Puerto Rican, etc.)	White, etc.  Specify: BL	
5-0036 led within 72 hours at tygiene. other than "natural the Medical Examin Completed by		College (1-4 or 5+)  2 yrs	a. Decedent's Usual Occupation during most of working life. DC	(Give kind of work done NOT use retired)	PRIVATE	/Industry
21215-0036 uld be filed within 7 Mental Hygiene. marked other than evevent, the Medica	DAMASIUS A. NIB	Λ	N	Mother's Name (First, Middle, GWA JUSTINA  Id Number or Rural Route Nu		te, Zip Code)
MD 21 md 2 should salth and Me em 27 is ma raumatic ev	JUDE NIBA/BROT		19b. Mailing Address (Street and 4436 STOCKBRIDG)  to of Disposition (Name of cemeter)		, MARYLAND	
Baltimore, MD 21215 permit. Pages and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked of injury or other traumatic event, the	1 X Burial 2 Cremation 4 Donation 5 Other Spec 21. Signature of Funeral Service Lin	ify:	natory or other place) MILY PLOT  22. Name and Address of		8 BAMENDA,C	
Physician Physician	X. D. M-ho	mplications that caused the death. Do	7474 Landove	r Road, Lando	ver, MD 207	785 Approximate Interval
/Medical caminer	failure. List only one cause or Immediate Cause (Final disease or condition resulting in death)	each line.  a. Bilateral Pulmonary Thror  Due to (or as a consequence of):				Between Onset and Death
ā	Sequentially list conditions, if any, leading to immediate	b. Deep Venous Thrombose  Due to (or as a consequence of):	S			
ted Insit	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C. Due to (or as a consequence of):				
0, e be executed ysician and burial - transit	UNPENDED	dAMENDED				
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transicial Contification: To Be Completed by Divisional Madical Expedition 1.	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unkn	23c. If yes, outcome of pregnar  Live birth Pregnant at time of death	2 Fetal death 3	Ectopic pregnancy	23d. Date of delive Month	ery Day Year
P.O. E res that the d signed by the be detached	3	ns contributing to death but not resu	liting in the underlying cause give		tobacco use contribute tes 2 No 3 Pr	
Division of Vital Records, I tal or Attending Physician: The law requires fire death.  **Al Director: After this certificate has been signed in by the funeral director, page 2 should be partification: To Be Completed.				pen		
Vital Rec ysician: The l his certificate l director, page	examiner?	Hospital: 1 Inpatient 2 ✓ E	101	Death (Check only one) her; Nursing Home 5	Residence 6 Oth	ner:
on of V ending Phy ath. or: After th the funeral c	27 Manner of Death	(Month, Day, Year)	8b. Time of Injury 28c. Injury a	at Work? 28d. Describe	e how injury occurred	
Division of To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After to completely filled in by the funeral Codition of Codition	2 Accident Investi 3 Suicide 6 Could detern	not be 28e. Place of Injury - At hom	e, farm, street, factory, office buil	ding, etc. 28f. Location or Town,		Rural Route Number, City
To the Hospital within 24 hours To the Funeral completely fille	_ 29a. Certifier 1 Certifying Phy	sician: To the best of my knowledge iner: On the basis of examination and and manner stated.	, death occurred at the time, date /or investigation, in my opinion, d	and place, and due to the ca eath occurred at the time, dat	use(s) and manner as st te and place, and due to	tated. the cause(s)
To A To	29b. Signature and title of certifier	40000	29c. License r O.C.M.		29d. Date signed (A September 23,	
R3		the completed cause of death (Item 2 stant Medical Examiner 1	3a) 11 Penn Street, Baltimor	e, MD 21201		
Stat Registra	te 31. Date filed (Month, Day, Year)	32. Registrar's Signatu	all!			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Year Antonina Frances Natoli October 4, 2008 9:10 a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Montgomery General Hospital Olney Montgomery If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) Social Security Number 6. Sex If Under 1 Year 7. Age (In vrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) Months Days 1 □ M 2 1 1 F 578-44-8710 85 Director 12. 1923 Washington, DC Aug. Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 🛣 No Maryland Montgomery Derwood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17713 Hollingsworth Drive 20855 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 😿 No Specify. 2 Specify: White 3 Widowed 4 □ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeping Accounting 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental I Joseph DeLuca Ruth Eunice East ပ္ is ma 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Burdette/Son-in-law Health a 17713 Hollingsworth Drive, Derwood, MD 20855 If item 27 or other t Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 permit. Page: Department o Important: If i any injury or **XX**Burial 2 ☐ Cremation 3 ☐ Removal from State October 7, 2008 4 ☐ Donation 5 ☐ Other (Specify) Olivet Cemetery Washington, DC 21. Signature of Funeral Service License Francis J. Collins Funeral Home Inc. Mu 500 University Blvd. W., Silver Spring, MD 20901 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Myocardial Infarction disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Respiratory Failure Sequentially list conditions, Examiner Divisits for as a consequency of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Day Year 5 Other (specify) the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed Dementia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 1 ☐ Yes 2**X N**0 2 □ No 1 □ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Yes 2√No Other: 4 \( \triangle \) Nursing Home \( 5 \) Residence \( 6 \) Other (Specify) Certification: To 1 Inpatient 2 I ER/Outpatient 3 I DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 28d. Describe how injury occurred 1x Natural 5 Pending To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 2 Accident investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and little of certifier 29d. Date signed (Month, Day, Year)

State Registrar

9

7 OCT DHMH 17 Rev 1/2001

www

Aruna Paspula, MD

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

. Registrar's Signature

18101 Prince Philip Drive, Olney, MD 20832

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] [] § Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** ZLEANOR MSTROWSKI 09 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 6/29/1915 9. Birthplace (State or Foreign Country)
New Jersey **Funeral** 1 M 2 F 145-07-4122 93 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show if than "natural", or items 23a or 28a-f show the Medical Examinar in ust be notified at 1 ☐ Yes 2 No Funeral Director Sea Girt New Jersey Monmouth 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 224 Stockton Blvd. 08750 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No <u>Ş</u> Specify: White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: if item 27 is marked other th any Injury or other traumatic event, the ODRE. Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Stanislaw Rospond Julia Brozvna ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John S. Ostrowski/ Son 1488 Tenbury Common, Annapolis, MD 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Entombment St. Catharine Cem. 10-13-08 Sea Girt, NJ 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signatural Service Licensee 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HEART **Physician** /Medical Due to (or as a consequence of): Examiner ASCULAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) PERTENSION Hospital or Attending Physiclan: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 MNo 23d. Date of delivery 3 D Ectopic pregnancy Month Year 5 ☐ Other (specify) been signed by the should be detached 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 **X**No 3 Probably 4 Unknown 1 □ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an within 24 hours after death.

To the Funeral Director: After this certificate has I completely filled in by the funeral director, page 2 s autopsy performed? Yes 2 No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated ٥ m who completed cause of death (Item 23a) (Type, Print) FENSE HIGHWAY ANNAPOUS MID 21401

15 W State

31. Date filed (Month, Day, Year) OCT 0 3 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 33554 Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Tally Kay Pappas October 0 A M 2008 0028 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner <u>33 Norman Allen Street</u> E1kton Ceci1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) Funeral Months 1 □ M 2 🗶 F Davs Hours Min. Yrs Director 217-64-4848 FEB 29, 1956 Michigan Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland ealth and Mental Hygiene. n 27 is marked other than "natural", or items 23a or 28a-f show r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No Maryland Ceci1 E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or than "natural", or items 23a or the Medical Examiner must be Funeral 33 Norman Allen Street 21921 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Black, White, etc. 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 🗓 No þ Specify: Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Thoroughbred Auction Elementary/Secondary (0-12) College (1-4or 5+) Maryland 21 X-Ray Repository Technician House 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Arthur Thomas Pappas Carol Bacchus 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any injury or other trau once. Kalli Pappas Webb/Sister 33 Norman Allen Street, Elkton, MD more, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State October 13 1 ☐ Burial 2 X Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) R. A. Ferris & Co., Inc. 2008 West Chester, PA 22. Name and Address of Facility
Hicks Home for Funerals, P.A.
103 W. Stockton Street, Elkton 21. Signature of Funeral Service Licensee Bal 23a. Part Enter the disease, or complications that caused the death. Do not enter the more of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical the IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ No 3 Probably 4 Unknown Completed 1 🗌 Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No autopsy perform 1□ Yes 2 X NO 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 | Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P this 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of After t 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide n 24 hou، the Funeral Dire the Funeral Dire Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 7

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

31. Date filed (Month, Day,

OCT 21

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Year)

2008

2

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 9<sup>Month</sup> **Physician** Jeanette Powell 28<sup>Day</sup> 2068 0430 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Prince Georges Hospital Cheverly Prince Georges If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days 1 □ M 2 🛣 F 577-62-9091 Director 62 July 9 1946 Washington DC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits 7 Is marked other than "natural", or items 23a or 28a-f shov traumatic event, the "hadeal Examinat must be realified at Md Landover Prince Georges Director 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20785 7509 Courtney Pl U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 ☐Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: ģ 3 Widowed 4 Divorced Specify: Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wil Department of Health and Mental Hygien Important: If item 27 Is marked other than any injury or other traumatic event, Inc. Food Service Techician Government <u>12th</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Andrew Terry Alma Smith ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William S. Powell/ Husband 7509 Courtney Pl Landover Md 20785 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1  $\square$  Burial 2  $\! \mathbf{X}$  Cremation 3  $\square$  Removal from State Riverdal" Crematory 10-7-2008 Riverdale Md 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McLaughlin Funeral Home 2019 MLK Jr Ave SE Washington DC 20020 tallerne 23a. Part 1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Fatal Cardic Arrhythmia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 by Physician/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 🗆 Ectopic pregnancy for Day Year 5 ☐ Other (specify) O. been signed by the should be detached 1 □Yes 2 No 9 Unknown 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No page 2 s autopsy perform 1 □Yes 2 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2**⊠**No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral E Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar Dr Gary

31. Date filed (Month, Day, Year)

OCT 0 2 2008

Cheverly Md 20785

3001 Hospital Dr

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Little

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

signed by the attending physician and d be detached for use as the burial-transit

**Funeral** 

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, Item Medican Examinar must be notified at any injury or other traumatic event, Item Medican Examinar must be notified at

**Physician** 

/Medical Examiner

Certification: To

Medical

Physician/Medical Completed by Be

icate has been s ; page 2 should l 124 hours after death.

• Funeral Director: After this certificate better filled in by the funeral director, pag Hospital or Attending Physician: within 2

State Registrar

31. Date filed (Month, Day, Year) 2008

29b. Signature and title of certifier

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 💹 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9135 30. Name and addres

6 ☐ Could not be

determined

			1 - For State Registrar	State of Ma	aryland		artment of F				giene Reg. No.	711118	33	557
	Physici		1. Decedent's Name (First, Middle, La Willi		v Pa	arks				2. Date of De Month Octobe	ath Day		3. Time of 1:20	Death A M
	/Medi Examir		4a. Facility Name (If not institution, gi		,	4110	4b. City, Town, or	r Location o	of Death			County of Death		21
			4355 Blossom Lan				Prince			k		Calvert		
	Funeral Director		214-05-2339	Sex 7. Age 1 ☑ M 2 ☐ F	e (In yrs. las 90	st birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da 07–13-	th ly, Year) -1918	9. Birth Cou Mar	olace (State ontry) y Land	or Foreign
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	cation						10d. Inside Ci	ity Limits
	Mary I-f sh fied a	tor	MD Calver	t			Prince	Fred	eric	k			1 □Yes	2₽No
	th the or 28a e noti	Director	10e. Street and Number				10f. Zip Code				10g. Citi:	zen of What Cou	ntry?	
	23a c		4355 Blossom Lan	е			20678					USA		
36	should be filed within 72 hours after death with the Maryland of Mental Hygiene.  marked other than "natural", or items 23a or 28a-f show marked other than "natural" are must be notified at imatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 17 Yes 2 1 N If #es, Give	lo		Was Decedent of H f Yes, specify Cuba 1 □ Yes 2🌠 No	ispanic Ori an, Mexicar Specify:	gin? (Spe n, Puerto	ecify Yes or No Rican, etc.)	-	14. Race - Americ Black, White, Specify:	etc.	
Ş	hour hural	ed b	15. Decedent's E	Year or Dates: 1		1	lent's Usual Occup	ation		_	16h Kir	Wh nd of Business/In	lite	
Maryland 21215-0036	filled within 72 h I Hygiene. other than "natuent, the Medica	Completed	(Specify only highest gr Elementary/Secondary (0-12)	ade completed)  College (1-4or 5		(Give	kind of work done of NOT use retired	durina mos	t of worki	ng	100.11	nd or business/in	dustry	
7.7	d with giene er tha , the l	E O	11	College (1-40) 5	+)	main	tenance e	ngine	er		Fed	leral Go	vernme	nt
ם	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Las	•				18. Mothe	r's Name	(First, Middle,	Maiden	Surname)		
<u>\</u>	es 1 and 2 should be of Health and Mental ittem 27 is marked or other traumatic eve	ဥ	George Conle	<del></del>					gare			<u>Paddy</u>		
Nar	12 sh h and 7 is m traum		19a. Informant's Name/Relationship				g Address (Street a							
	1 and Health em 27		Grace E. Parks,	spouse	20b. Plac	ce of Dispo	Blossom sition (Name of			nce Fre		ck, MD 2		
saitimore,	Pages nent of I ant: If ite ury or o		1 🌠 Burial 2 □ Cremation 3 [		cen	netery, crer	natory or other plac	· i				-	,	
	permit. Page Department of Important: If any injury or once.		4 ☐ Donation 5 ☐ Other (Speci 21. Signature of Funeral Service Lice		SL.		s' Parish . Name and Addres			-2008		hian, M 1 Home,		
ñ	Dep any		William X	Tier		1	3325 Mt.		114					
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	pplications that caused	the death.					(4)			Approximat Interval Bet	e
3 <u>.</u>	Physician		Immediate Cause (Final disease or condition	<\f	LOY								Onset and	
¥	/Medical Examiner		resulting in death)	Due to (or as a										
	Examilier Examilier	پ	Sequentially list conditions,	b. —										
	ted	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	i consequei	nce ot):								
,	icate be executed physician and s the burial-transit	xan	that initiated events resulting in death) Last	CDue to (or as a	consequer	nce of):								
8/PU	e be (siciar	dical E	· ·	d										
ğ	certificate be executed iding physician and ise as the burial-transit	/ledi												
X D D	death certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome p	of pregnanc		Ectopic pregnancy				2	3d. Date of deliver	. ,	
	e dea he att	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at 9□Unknown			Other (specify)		_			Month	Day `	Year
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ĕ	sician: The law s certificate has b irector, page 2 sh	Completed								24a. Was autop		24b. Were auto prior to co death?	psy findings mpletion of c	available ause of
		e Co	25. Was case referred to medical					00 81		1□ Yes	2 No	1 ☐ Yes	2□No	
	Physician: r this certific ral director,	To Be	examiner?	Hospital: 1 ☐ Inpatier	nt 2□FE	3/Outnatien	t 3 □ DOA Othe			(Check only o		☐Other (Specif	£ .1	
5	g Ph		27. Manner of Death	28a. Date of Injur	y 2	Bb. Time of Injury	28c. Injury Work			28d. Describe			у)	
VISION	endin ath. or: Aff	atio	1 ■ Natural 5 □ Pending 2 □ Accident investigatio	n	rear)	Hijuty		Yes 2 1	No					
Š	tal or Att s after de al Direct ed in by t	Certification:	3 Suicide 6 Could not b 4 Homicide determined	e 28e. Place of inju- building, etc	ry - At home . <i>(Specify)</i>	e, farm, stre	eet, factory, office		2	28f. Location (8 City or Tov		Number or Rura	al Route Num	ber,
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director,	Medical (	29a. Certifier (Check only one)	nysician: To the best o miner: On the basis of and manner stat	examinatio	edge, death	occurred at the time vestigation, in my of	ne, date an pinion, dea	d place, a	and due to the ed at the time,	cause(s) date and	and manner as s place, and due t	tated. o the cause(s	3)
	To the within comp	Me	29b. Signature and title of certifier				29c. License		0.4			e signed (Month,		
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			30. Name and address of person who	completed cause of de	ath (Item 23	Ba) (Type, I	Print)			/		,		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Warren Α. Payne 10/02/2008 Α 2:21 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 M 2 □ F 577-44-7494 Director Washington, April 1,1934 \_DC Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Marylanc 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show in than "natural", or items 23a or 28a-f sho Director 1√2 Yes 2 No MD Prince Georges Hyattsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6303 23rd Ave. 20702 Funeral USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces? 1- Yes 2 □ No Black, White, etc. 1 Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2K Married 1 ☐ Yes 2 No Specify ð Specify 3 Widowed 4 Divorced Black. Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event, In e. M. any Injury or other traumatic event, In e. M. once. Private 2yrs Entrepreneur 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John F. ၉ Payne Emma B. Childs 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary L. Payne/ Wife 6303 23rd Ave., Hyattsville, MD 20702 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Riverdale Park Crem. 10/08/08 Riverdale, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Johnson & Jenkins Funeral Home 21. Signature of Funeral Service Linenses 716 Kennedy St. NW, Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine the Hospital or Attending Physician; The law requires that the death certificate be executed and the burial-trait Due to (or as a consequence of): attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an certificate 1 □Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 1/Inpatient 1 ☐ Yes Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

within 2 To the I

Division of Vital Records. P.O. Box 68760.

Baltimore, Maryland 21215-0036

31. Date filed (Month, Day, Year) State 8 2008 0 Registrar

29b. Signature and title of certifier

ON 1011

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death 9/29/2008 **Physician** Gordon Edward Phipps Sr. 1540 ™ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 5/19/1921 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours XXM 2□ F 87 Director 219-16-0067 Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination and any once. 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2√ No Director Anne Arundel Harwood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4570 Owensville Sudley Rd. 20776 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status 1 ☐ Yes ♣ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No White Specify þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mail Carrier US Postal Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Thomas A. Phipps Mary O'Neil 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thelma Phipps 4570 Owensville Sudley Rd. Harwood, Rd 20776 Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Our Lady of Sorrows 10/4/2008 Owensville, MD 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Poneral Service Licenses Jalu 12 Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final acute Myo Card hours **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Examine Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) ☐Yes 2☐No sate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy within 24 hours after death.

To the Funeral Director: After this certificate to completely filled in by the funeral director, page 1 ☐ Yes 2 ANO 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 🕅 ER/Outpatient 3 ☐ DOA ဥ 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 □ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier **Medical** and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 16 Rd. West ichbaum OWCUS

Registrar

State

31. Date filed (Month, Day, Year)

0 3 2008

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Ye at Month 4:52 PM OCTOBER CATHERINE ANNA PROCTOR 2008 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) CIVISTA MEDICAL CENTER LAPLATA CHARLES If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, SEPT 5 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign . 1937 Days Hours MARYLAND 1 □ M 2 🗓 F 217-36-8324 71 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 🎇 No WALDORF CHARLES 10f, Zip Code 10g, Citizen of What Country? 10e. Street and Number 20603 UNITED STATES 9945 BUNKER HILL ROAD 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 Never Married 2 Married 1 □Yes 2 No Specify Specify: BLACK 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) FEDERAL GOVERNMENT JANITORIAL SERVICES SUPV. 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) SUSIE SAVOY OUEEN WILLIAM OUEEN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2154 PINEVIEW COURT, WALDORF, MD 20601 CELESTINA A. FORD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Surial 2 ☐ Cremation 3 ☐ Removal from State JOSEPH'S CH. CEM OCT. 7, 2008 4 ☐ Donation 5 ☐ Other (Specify) ST. POMFRET, MARYLAND 21. Signature of Funeral Service Licenses LYDIA C. THORNION JOHNSON M60383 22. Name and Address of Facility THORNION FUNERAL HOME, P.A 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Approximate Interval Between Onset and Death tegs disease or condition resulting in death) Due to (or as a consequence Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Vear 5 Other (specify) 1 □ Yes 2 □ No. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 - No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2-1 No 2 ER/Outpatient 3 □ DOA 1 Inpatient 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d, Describe how injury occurred 28c. Injury at Work?

Physician /Medical **Examiner** 

Baltimore,

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

Be

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MD

**Funeral** 

Director

with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, traumatic event, traumatic event.

burial the use as for page director

law requires that the death certificate be executed

P.O.

Division of Vital Records,

Physician:

Attending

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death.

and attending physician the þ signed b has certificate After this funeral within 24 hours after death To the Funeral Director: the filled in by

Examiner

à Completed Be Certification: To

Physician/Medical

BB 10

29b. Signature and title of certifier

5 Pending

investigation

determined

6 ☐ Could not be

1 Natural

2 Accident

4 Homicide

(Check only

3 ☐ Suicide

29a. Certifier

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

License number

1 🗲 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 ☐ Yes 2 ☐ No

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d, Date signed (Month, Dav. Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

107 Waldorf MD 2060 31. Date filed (Month, Day

State Registrar

Medical

0 6 2008

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year JUNIOUS KUBERTS 10:00 A M 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HYATISVILLE HYATISVILLE CARE MANDE Georges If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 228-40-4454 1**X** M 2□ F Director VIEGINIA Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or Itams 23a or 28a-f show other traumatic svent, the Madical Examinar must be notified at HYATTSVILLE GEOVARO 1 Xes 2 □ No Director MD Heince 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 20783 6500 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 25 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: BLACK Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE BRICK LAYER CONSTRUCTION permit. Pagas 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked other any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame), James HUMBRIS Acimathea 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11310 KETTERING WAY UPPECHARLBURD HID 20774 DAUGHTER Valencia MARTIN 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 10/6/08 RIVERDALE POLL CREHADOLY 21. Signature of Funeral Service Licana SIFURSHUR ST NW WASH OC 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician SEPTIC SHOCK /Medical Due to (or as a consequence of): Examiner PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the attending physician and hed for use as the burial-transit The law requires that the death certificate be executed DYSPHAGIA Due to (or as a consequence of) Box 68760 DEMOUTIA Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Day Year Month 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 1 ☐ Yes 2 ☐ No 9☐ Unknown 9 Unknown signed b Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CONEBROVASCULAR ACCIOENT 1 Yes 2 No 3 Probably 4 Munknown Completed HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 2 No 1 Yes 1 Yes To the Hospital or Attending Physician: "within 24 hours after death."

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗙 No 2 3□ DOA After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: d in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 108 47867 duress of person who completed cause of death (Item 23a) (Type, Print) 4701 RANDOLPH ROAD HZIG RUCKVILLE HO LUMIGA 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State 0 6 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien@ 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** 4<u>,</u> 2008 7:55 p M October Randie LaVerne Randolph /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a, Facility Name (If not institution, give street and number) Examiner Dunkirk Hinder 24 Hrs. Calvert 2209 Skyvilla Drive If Under 1 Yea 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 💢 F Months Days Hours Min 63 9/29/1946 Director 219-46-5475 Maryland Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10b. County 10a State your j r 28a-f show notified at 1 Yes 2 No Director Dunkirk Calvert MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or Items 23a or Examiner must be r 20754 USA 2209 Skyvilla Drive death Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: þ White 3 ☐ Widowed 4 X Divorced "natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Medica (Give kind of work done during most of working life. DO NOT use retired) than " Elementary/Secondary (0-12) College (1-4or 5+) Well drilling co. 12 Secretary other 1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 7 is marked o LaVerne Barber Clarence Randolph 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2209 Skyvilla Dr., Dunkirk, MD 20754 Timothy Williams/Son 27 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or ot 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 10/7/08 Beltsville, MD Chesapeake Crem. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Raymond-Wood F.H., P.A. Dunkirk, MD 20754 PO Box 430, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** eukemia rars disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease of Injury that initiated events resulting in death) Last physician and s the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4⊡Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 KNo Division or Vital Records, P.O. 9□Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an autopsy 2 XNo 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ဥ 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification: After Injury 1 Natural 5 ☐ Pending investigation 1 Tyes 2 No Director: / 2 Accident 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours after de Funeral Direct 4 Homicide 29a. Certifier ī Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 24 the 29d. Date signed (Month, Day, Year)
October 67, 2008 29c. License number 29b. Signature and title of certifier D0059061

LRW

31. Date filed (Month, Day, Year) OCT

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registras Signature

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Prince Frederick, MD 20678

2008

State

Registrar

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FRANCISCO 31. Date filed (Month, Day, Year) OCT 1 0 2008

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANDMARE 350 MICL 57. ANDRAGE egistrar's Signature

Registrar

29c. License number 0 27898

29d. Date signed (Month, Day, Year)

TAGERSTOWN

		,	1 - State Registrar	,	Cei	tificate of	Death	Reg. Ng. 008 3356				1	
		121	1. Decedent's Name (First, Middle, La	st)	2. Date of Death								
Ŀ	Physici /Medic		Myron	Eugene		Rice		Month Octob	er 1	, 2008	1906	M	
	Examin		4a. Facility Name (If not institution, give			4b. City, Town, o	Location of Death	1	4c.	County of Death			
		W,	WMHS-Braddock Ca				erland			Alle	gany		
	Funeral		5. Social Security Number 6. \$ 160–16–0451	Sex 7. Age (In yrs. la 1 ☑ M 2 ☐ F 89	nst birthday) Yrs.	if Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	ıy, Year)	Cou	place (State or Forei intry)	gn	
	Director		Usual Residence of Decedent	09	710.			04/14/	1919	Pen	nsylvania	_	
	/land ow		10a. State 10b. County	10c. City,	Town or Lo	cation	<del></del>				10d. Inside City Limit	ts	
d 21213-UU36 filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ont, the Medical Examiner must be notified at		tor	MD A1	legany		Cumberla	nd				1 □Yes 2 🔀 N	0	
	r 28a	Director	10e. Street and Number			10f. Zip Code			10g. Citi	zen of What Cou	country?		
	th wit	al D	13524 McMul	len Highway		2	1502			USA			
	ems ems	Funeral	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	3. 13.	Was Decedent of H f Yes, specify Cuba	ispanic Origin? (Span, Mexican, Puert	pecify Yes or No	)-	14. Race - Amer Black, White		_	
ð	or it	y FL	1 Never Married 2 Married	1 XYes 2 No 194	<u>4</u> _	1 ☐ Yes 2☐ No	Specify:			Specify:	, 610.		
9500-61212	ural"	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates: 194	5	•			101 10		White		
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7	within ene. than he M	ш	Elementary/Secondary (0-12)	College (1-4or 5+)		Lesman	<i>'</i> /		1.71.	1 1 .			
0	filed Hygi Sther	ŏ	17. Father's Name (First, Middle, Last		sa.	Lesman	18. Mother's Nam	ne (First, Middle		nolesale Surname)	er	_	
<u>a</u>	ld be ental ked c	To Be	Russell	R	ice		Pearl			St	reett		
Maryland	ss 1 and 2 should be filed within 72 hours after death with the Marylan of Heath and Mental Hygiene. Iftem 27 is marked other than "natural", or items 23a or 28a-f show to ther traumatic event, the Medical Examiner must be notifiled at	-	19a. Informant's Name/Relationship (	Type. Print)	19b. Mailir	ng Address (Street	and Number or Ru	ral Route Numb	er, City o			_	
2	and 2 lealth a m 27 is her trai		Adalee R. Rice /	Wife	1352	H McMulle	n Highwa	y, Cumbe	erlar	nd, MD	21502		
ē,	tem of Hei		20a. Method of Disposition	CO	ace of Dispo	sition (Name of natory or other place	T T	Date		cation - City or T		_	
Ē	Page nent c int: if		1 🕅 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Speci.	JHemoval from State	•	em @ Rock	i	/06/200	3 F1	lintston	e MD		
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מ	o a Lu		- King (	dum	1	104 Decat	ur Stree	t, Cumbe	erlar	nd, MD	21502		
			23a. Part1. En er the disease, or com shock, or heart failure. List only	plications that caused the death.	. Do not ent	er the mode of dyin	g, such as cardiac	or respiratory a	rrest,		Approximate Interval Between		
	Physician		Immediate Cause (Final disease or condition	a Coronary He	art. Di	90290					Onset and Death  5 vears		
	/Medical		resulting in death)	Due to (or as a consequence		beabe					<u>J years</u>	_	
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2	death certificate be executed e attending physician and id for use as the burial-transit												
08/00	ficate phys s the	Medical		<b>d</b>									
X	w requires that the death certific been signed by the attending F should be detached for use as	-	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pregnan						23d. Date of deliv	verv		
ň	death a atte d for	hysician	in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de		]Ectopic pregnancy ] Other <i>(specify)</i>				Month	Day Year		
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S,	s tha	ру Р	Part II. Other significant conditions	contributing to death but not resul	ting in the ur	nderlying cause give	en in Part I.	23e. Did t	obacco u	se contribute to	the cause of death?		
ğ	requires een sign							1 🗆	Yes 2[	XNo 3□ Pro	bably 4 ☐Unknow	/n	
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$\leq$	or Al titler d Direct in by	Certification:	4 ☐ Homicide determined		ne, farm, str	eet, factory, office			tion (Street and Number or Rural Route Number, or Town, State)				
_	pital ours a eral filled		29a. Certifier 1 X Certifying Pt	nysician: To the best of my know	ledge death	a occurred at the tir	no, data and place	and due to the	201100(0)	and manner on	etated	_	
	24 hos 24 hos Fun etely	edical	(Check only 2 Medical Examone)	miner: On the basis of examination and manner stated.	on and/or in	vestigation, in my o	pinion, death occu	rred at the time,	date and	place, and due	to the cause(s)		
	To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After t completely filled in by the funera	Me	29b. Signature and title of certifier			29c. Licens	e number		29d. Dat	e signed (Month	, Day, Year)	_	
,	5+		Mah to	1 Kann	()	DO	014865		C	October	2. 2008		
	5+		30. Name and address of person who	completed cause of death (Item :	23a) (Type,	Print)			October 2, 2008				
	MA		Robustiano J.	Barrera, M.D.		Memoria	l Avenue,	Cumber	land	1, MD 2	1502		
	Sta	te	31. Date filed (Month, Day, Year)	2. Registrar's Signatu	ure de								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Rea. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Vear **Physician** Edward Ristaino Richard 8:08 a<sup>M</sup> 1, 2008 October /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner MONTGOMERY WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 X M 2 □ F 71 6/22/1937 New Jersey Director 218-30-1988 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. Count 10a. State 28a-f show other traumatic event, the Modical Examiner must be notified at 1 √ Yes 2 No Director Silver Spring Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 23a or 20901 USA 9039 Sligo Creek Parkway, apt. 601 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give AirForce Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 "natural", or 1 ☐ Yes 2 No Specify. Specify white δ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) State Department agent marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) d 2 should be fill the and Mental F. 7 is marked oth Be Sally Ann Brittingham Michael Edward Ristaino ం 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) s 1 and 2 s of Health ar item 27 ls 2700 Blaine Dr., Chevy Chase, MD 20815 Elizabeth Ann Timberlake/daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages of ortant: If i 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page: Department o Important: If any injury or 4 □ Donation 5 □ Other (Specify) Parsons Cemetery 10/2/08 Salisbury, MD Signature of Funeral Service Licensee 22 Name and Address of Facility al Home Professional Association CFSP 501 Snow Hill Rd., Salisbury, MD 21804 Kompson Approximate Interval Between Onset and Death Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last onsequence of): Examiner transit the death certificate be executed and burial-t Box 68760 the attending physician PRYMORAS Physician/Medical as the IF FEMALE: asn If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day 0 in the past 12 months? Month Year signed by the a d be detached for 5 Other (specify) □Yes 2□No o 9 Unknown ٥. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown should should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 2 No 1 □Yes 2 PNo 1 ☐ Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗷 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 1 Natural 5 ☐ Pending investigation 1 ☐Yes 2 ☐No death. 2 Accident after death completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated To the I within 2 To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title

Registrar

30. Nan

Date filed (Month

address of person who completed cause of death (Item 23a) (Type, Print)

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien® Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death Month Day Year September 29,2008 Physician 0730 A M Robert Sailor, Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Suburban Hospital Bethesda If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Days Hours 1⊠ M 2□ F 041-26-7330 75 7/11/1933 **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Marylanc r 28a-f show 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Prince George's Upper Marlboro 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code item 27 is marked other than "natural", or items 23a or other traumatic event, the Madical Examinar must be 13401 Leesburg Place Funeral 20774 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 X Yes 2 □ No If Yes, Give 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐Yes 2 ☑ No Specify Š Korea Specify: Black 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Supply Officer U.S. Gov't 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Sailor Annie Gay ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 1309 Pickering Circle, Upper Marlboro, MD 20774 Health a Francine L. Travis/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1 Department of I Important: If ite any Injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Cemetery 10/6/2008 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Ft. Lincoln Funeral Home 3401 Bladensburg Rd., Brentwood, MD 20722 23a. Part 1. Enter the disease, or complications the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final HRONCE OBSTRUCTIVE PULMONARY **Physician** disease or conditi-resulting in death) /Medical Due to (or as a consequence of): Examiner CONGSTIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 3 cate has been si page 2 should b 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed certificate 1 ☐Yes 2 ☑No 2 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death P Hospital or Attending P 24 hours after death. Pruneral Director; After to 28b. Time of After t 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide To the Hospital within 24 hours a To the Funeral I † Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) Bro, MO 0005 7124

31. Date filed (Month, Day, Year) State OCT 0 2 2008 Registrar

Truong Bao, MD 10110 Molecular Dr., Rockville, MD 20850 32. Registrar's Sign ture

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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	State of Maryland / Department of Health and Mental Hyd	iene

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п	Physici		Donna M	Marie Sc	hmeltz					Month Oct. 4	Da 21	008	Year	6:45	Рм		
	/Medic Examir				give street and num	nber)		4b. City, Town,	or Location of Death	-		c. County of Death					
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21215-0036	permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: if itam 27 is marked other than "natural", or items 23e or 28e-f show say injury or other traumatic avant, the Medical Examinar must be notified at ODGE.	þ	1 Never Married 2 Married  1 □ Yes 2 No  If Yes, Give Year or Dates:									Specify:	White,				
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	To the Hospitel or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificete hy completely filled in by the funeral director, page	Medical C	29a. Certifier (Check only one)	1 Certifying 2 Medical E	Physician: To the caminer: On the ba and mann	sis of examination a	ga, daar ind/or in	occurred at the ti vestigation, in my	me, data and place opinion, death occur	and due to the great at the time,	date an	) and man d place, ar	nor ac cl	ated. the cause(s)	)		
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	Sta	ite	31. Date Glad (Mor	6 2008°	32. Re	gistrar's Signature	Les .	3-1-100	1 1 1-163			-					

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2008 **Physician** Spies October 1, /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Calvert Solomons Asbury-Solomons Health Care Center 9. Birthplace (State or Foreign Country) New York Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1**™** M 2□ F 75 124-26-3146 12/02/1932 Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 10a, State Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at Calvert MD Solomons Director 10a. Citizen of What Country? 10f. Zip Code 10e Street and Number 20688 United States 11450 Asbury Circle, Apt. 401 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 þ White 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Investment Financial Planner 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alice Elizabeth Bryan Edward William Spies 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Gregory Miller (Nephew) 11634 Bayonet Ln., New Port Richey, FL 34654 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of Himportant: If ite any injury or ot 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan Crematory 10/4/08 Alexandria, Virginia 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Rausch Funeral Home, P.A. P. O. Box 600, Lusby, Maryland 20657 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Divertical Examiner Sequentially list conditions, Due to for as a consecut cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-transit Due to (or as a consequence of) Physician/Medical the attending pl þ Completed

the Hospital or Attending Physician; The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, page 2 certificate within 24 hours after death.

To the Funeral Director: A
completely filled in by the fi

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Certification: To

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IF FEMALE: 23b. Was decedent   in the past 12 n 1 ☐ Yes 2 ☐ 9 ☐ Unknown	nonths?		23d. Date of delivery Month Day Year										
Part II. Other signific	cant conditions	contributing to death but not resu	liting in the underlying cau	se given in Part I.	23e. Did tobacco	use contribute to the cause of death? ☑ No 3 ☐ Probably 4 ☐ Unknown							
					24a. Was an autopsy performed? 1□ Yes 2 → 1	24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No							
25. Was case referre	ed to medical	26, Place of Death (Check only one)											
examiner?	Го	Hospital: 1   Inpatient 2   1	ER/Outpatient 3 DOA	lome 5 Residence	6 □Other (Specify)								
27. Manner of Death  1 Hatural  2 Accident	5 ☐ Pending investigation		28b. Time of Injury M	c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how inju	ary occurred							
3 ☐ Suicide 4 ☐ Homicide	6 Could not b determined		28f. Location (Street a City or Town, State	nd Number or Rural Route Number, e)									
29a. Certifier	Certifying Pl	hysician: To the best of my know	wledge, death occurred a	t the time, date and place	e, and due to the cause(s	s) and manner as stated.							

and manner stated 29b. Signature and title of certifier

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number

October 1, 2008

1:15 P. M

10d. Inside City Limits

Approximate Interval Between Onset and Death

1 ☐ Yes 2 No

30. Name and ad less of person who completed cause of death (Item 23a) (Type, Print)

J. John Barth, III, MD 14090 Solomons Island Road, Solomons, Maryland 20688

State Registrar

32. Registras Signature 31. Date filed (Month, Day, Year) 2008 OCT

drw 10

		_ For		State of Ma	aryland / De				-						
		State Registrar			(	Certifi	cate of E	Death		Reg. No.	008	33570			
Physicia	an	Decedent's Name (F.		via Edm	onia Sull	ivan			2. Date of De Month	Day	Year <b>2008</b>	3. Time of Death			
/Medic		4a. Facility Name (If no.			onia Suii			Location of Death	October	<del></del>	bunty of Death	1:15 P <sup>™</sup>			
Examin	er	7865 Mt. Har					Owings			Cal	Calvert				
Funeral		5. Social Security Numb	ber 6. Sex	7. Age	(In yrs. last birth	Mo	Under 1 Year onths Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th ly, Year)	9. Birth Cou	place (State or Foreign ntry)			
Director		213-38-3312 Usual Residence of Dec	2	IVI Z	68 <sup>Y</sup>	S.		,	October	23, 19	39 Ma	ryland			
/land			b. County		10c. City, Town	or Locatio	n					10d. Inside City Limits			
Mary a-f sh	ctor	MD	Calvert		Owings							1 □ Yes 2 □ X o			
be filed within 72 hours after death with the Maryland rtal Hygiene. Ital Hygiene. Ital Hygiene. Ital Han "natural", or items 23a or 28a-f show event, it of headen Examination relified at	Director	10e. Street and Numbe	er			10	0f. Zip Code			10g. Citize	g. Citizen of What Country?				
ath wi		7865 Mt. Har						20736		USA					
er de	Funeral	11. Marital Status  1 □ Never Married		<ol> <li>Was Decedent E Armed Forces?</li> <li>1 □ Yes 2 □ M</li> </ol>		13. Was If Yes	Decedent of His s, specify Cubar	spanic Origin? (Si n, Mexican, Puerto	pecify Yes or No Rican, etc.)	- 14	. Race - Ameri Black, White,				
irs aff	ρ	3 X Widowed 4 □		If Yes, Give Year or Dates:		1 🗆 \	∕es 2.∐XNo	Specify:		S	pecify:	Black			
72 hou	Completed		i. Decedent's Educa only highest grade		16a. [	ecedent's	s Usual Occupa	ition uring most of work	kina	16b. Kind	of Business/Ir	ndustry			
ithin he.	mple	Elementary/Seconda	ary (0-12)	College (1-4or 5	+)	ite. DO N	IOT use retired)	ing most or non	9		D 11: 0:	h			
lled w lygie ther ti	CO	17. Father's Name (Firs	et Middle Last)	ļ		School	Teacher	18. Mother's Nam	ne (First Middle	Maiden Su	Public Sc	chools			
d be fi ental l ced of	Be	17. Fathers Name (Firs		ord Diago				10. Would b Hall		ueenie					
should not Me mark	2	19a. Informant's Name	James Edw e/Relationship (Typ		19b. I	Mailing Ad	dress (Street a	nd Number or Ru	_			p Code)			
alth a 27 is		Stacey S. M.	arshall - Dau	ghter		3607 V	Vabash Av	enue, Baltin	nore, MD 2	21215					
es 1 a of He fitem		20a. Method of Disposi			20b. Place of I	Disposition cremator	n (Name of ry or other place	9)	Date	20c. Loca	tion - City or T	own, State			
Pag ment ant: I		4 □ Donation 5 □		moval from State	C		Cemetery		1/2008	Shell	oyville, KY	•			
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Inspertment of Health and Mental Hygiene. Insportant: I file m 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Mealest Examination instituted at once.		21. Signature of Funer	ral Service License	20			me and Addres								
22200		23a. Part 1. Enter the c	7.00		the death. Do no						, Prince Fr	ederick, MD 2067 Approximate			
Dhysisian		shock, or heart fa Immediate Cause (Fina	ailure. List only one	cause on each lin	ne.	. 14	10010		· ^	۸	testino	Interval Between Onset and Death			
Physician /Medical		disease or condition resulting in death)	a.	Due to (or as	a consequence of	): 	eusias	H- 1/1/2	tastas	in	ues in	#			
Examiner		Constant list on a list	iana h	·			· Wi	ω.		11 Month					
p ti	xaminer	Sequentially list conditi if any, leading to immed cause. Enter Underlying	diate	Due to (or as	a consequence of	):									
executed and al-transit	хаш	Cause (Disease or inju that initiated events resulting in death) Last	C.	Due to (or as	a consequence of	):									
sician buria	alE					,-									
ifficate g phys	edic		d.												
Attending Physician: The law requires that the death certificate be executed refers. After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pre	egnant	c. If yes, outcome	of pregnancy 2   Fetal death	3 □ Ect	topic pregnancy	,		23	d. Date of deliv				
e deal	sicia	in the past 12 mo 1 □ Yes 2 🌠 No 9 □ Unknown		4 ☐ Pregnant a 9 ☐ Unknown			ner (specify)				Month	Day Year			
e law requires that the de has been signed by the le 2 should be detached		Part II. Other significal	int conditions cont	ributing to death be	ut not resulting in t	he under	lving cause give	en in Part I.	23e. Did	tobacco use	contribute to	the cause of death?			
uires t n signe	d by						, , ,		1 🗆	Yes 2□	No 3□ Pro	bably 4 Unknown			
w requ	Completed						-		24a. Was	an	24b. Were aut	opsy findings available			
The la te ha:	ошр				-				auto perfo 1 □ Yes	psy ormed? 2 No	prior to c death? 1 ☐ Yes	ompletion of cause of			
lan:	Be C	25. Was case referred examiner?	to medical					26. Place of Dea			1 🗆 103	2010			
hysic his ce	To E	1 Yes 2 No	Ho	ospital: 1 🗌 Inpatie	ent 2 ER/Out			4 Li Nursing n			☐ Other (Spec	ify)			
ling P	ion:		5 ☐ Pending	28a. Date of Inju (Month, Da		28c. Injury Work M 1 □ \	/at ? /es 2 □No	28d. Describe	how injury (	occurred					
death death ctor: y the 1	icat	2 Accident 3 ☐ Suicide	investigation 6 ☐ Could not be	28e. Place of Inju	urv - At home, farr			res 2 🗆 No	28f. Location /	Street and	Number or Ru	ral Route Number,			
al or A s after il Direction by	Certification:	3 ☐ Suicide 4 ☐ Homicide  See. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location City or To													
To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical C		Certifying Phys  Medical Examin		f examination and										
o the vithin o the comple	Mec	29b. Signature and title	e of certifier	and mainer ste			29c. License	_		29d. Date	signed (Month	, Day, Year)			
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State Registrar

Af M.D. 2417 Solomows Isld Rd. Hantingtown, Md. 20639
72008 July & Spells ZAHIR Yousaf 31. Date filed (Month, Day, Year) OCT 7 20

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 21285PM Alexander 2008 OCTOBER. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 30, Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 🔣 M 2 🗆 F 19 043-86-7155 1989 Connecticut Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show must be notified at 1 ☐ Yes 2 X No Director 28a-f St. Leonard Maryland Calvert 10f. Zip-Code 10g, Citizen of What Country? 10e. Street and Number 6 20685 United States 23a 7450 Bond Street by Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. int: If item 27 is marked other than "natural", or ite 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Student College 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pamela Lynn Gallagher Mark Allan Shubert ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7450 Bond Street, St. Leonard, MD 20685 Mark Allan Shubert / Father other 20a. Method of Disposition
1 

Burial 2 

Cremation 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of himportant: If ite any injury or of once. 3 Removal from State 10/03/2008 Alexandria, Virginia 4 Donation 5 Other (Specify) Metropolitan Crematory 21. Signature of Funeral Service License 22. Name and Address of Facility Rausch Funeral Home, P.A. P.O. Box 600, Lusby, MD 20657 23a. Part 1. Enter the disease, or complications that caused ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each lin Onset and Death Immediate Cause (Final Cystic FI brosis **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) law requires that the death certificate be executed attending physician and I for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) ate has been signed by the all page 2 should be detached to 2 No P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 2 No 1 Yes Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 🔁 No Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specity) 2 ER/Outpatient 3 DOA 1 TYes ၉ completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending Injury 5 Pending investigation 1 🗌 Yes 2 No 2 Accident Director: Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral C 29a, Certifier 1 (Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signatu 29c. License number 29d. Date signed (Month, Day, Year) 00 ress of person who completed cause of death (Item 23a) (Type, Print) LRW 600 North Wolfe St, Baltimore, MD, 21287 31. Date filed (Month, Day, Year) 32. State OCT 2008 Registrar

08-07321 Stephen Sadelson

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1- For State Certificate of Death Reg. No.															
Physicia		1. Decedent's Name (First, Middle										. Date of De Month		Year	3	Time of Death	
ledical Exami	ner	Stephen Mic										Septemb	er 26, 200			0704 hrs	
		4a. Facility Name (if not institutio	n, give stre	eet and number	)		4t	City, To		ocation of	Death		1	unty of [	Death		
2-		3811 Carson Court						Hunting					Calv				
uneral		5. Social Security Number	6. Sex	7. Ag	ge (In yrs.	last birth	iday)	If Under		If Under			irth(MM/DD/		J. Birthr oreign	lace (State or	
Director		216-15-7234	1 X M	2 F	27		Yrs.	Months	Days	Hours	Min.	09/27	/1980	- 1	Coun	try) MD	
	-	Usual Residence of Decedent	75						L								
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ž .,1		MD Calv	ert			H	unti	ngtov	vn							Yes 2 X	No 2
daryland 28a-f show 1 at once.	용	10e. Street and Number						10f. Zip C	ode				10g. Citizen	of What	Countr	y?	
th the Maryland 23a or 28a-f sho notified at once.	Director		701170+				1		206	30			II.	S.A			
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filed at Hy	Be C	James Michae										ey Anr	ne Amla	and			
21215-0036 hould be filed within 7 Id Mental Hygiene. is marked other than tire event, the Media		19a, Informant's Name/Relations				19b	. Mailing	Address	(Street				umber, City o		State, 2	Zip Code)	
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. I faiten 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once		Shirley Sypul		-									own, M				
and 2 and 2 ealth teun 2 traun		20a. Method of Disposition			20b			ion (Name	e of cem	etery,		Date 20c. Location - City				own, State	
Ore ges 1 of H if i		1 Burial 2 X Cremation		Removal from S	tate		ory or oth				10/0	02/2008 Clinton, MD				MD	
Lim Pag ment tant:		4 Donation 5 Other Specify:										Elino1	2 10				Α.
Baltimore, MD 2 permit. Pages 1 and 2 shoul Department of Health and M Important: If item 27 is m injury or other traumatic.		21. Signature of Funeral Service	111				22. N	ame and A	adress (	or Facility	M BI	rd (	) Wings	ME	20	736	
		Lisa M. Mou		V	d the dest	h Dono										Approximate Ir	nterval
Physician		failure. List only one cause			a trie geat	n. Do no	n enter tr	e mode or	uying, s	iga i as o	al Glac Oi	respiratory t	arcot, orroot,	01 11001		Between Onse Death	
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		or condition resulting in death)  Due to (or as a consequence of):															
¥ )	ᡖ	Sequentially list conditions, if any, leading to immediate	D	to (or as a con	sequence	of):											
· ·	틸	cause. Enter Underlying Cause	C						_								
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	ian	past 12 months?		Live birth Pregnant	at time of	-	Fet Ott	ardeath ner (Spec		Letopi	o progriai	icy	""	,,,,,,		-,	-
Box 687  Re death certifice the attending properties as the	Physicia	1 Yes 2 No 9 Ur	known	death			J _ Ou	iei (opec	<b>y</b> /								
D. Entrithe cached		Part II. Other significant condi	tions co	ntributing to dea	ath but not	resultin	g in the u	nderlying	cause gi	iven in Pa	art I.	23e. Did	tobacco use	contrib	ute to t	ne cause of dea	th?
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Vid This all dire	흔	1 <b>✓</b> Yes 2 No	HUS	т піра	tient 2		utpatient					g Home 5	Residence			Scene	
Division of Vital Records, tal or Attending Physician: The law require is after death.  In Director: After this certificate has been sifed in by the funeral director, page 2 should b	اۋا	27. Manner of Death		28a. Date of Ir FOUND: Day	njury ',Year)		Time of It	njury 2	-	y at Work	. [9		e how injury anged sel		u		
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Division Spital or Attend tours after death. neral Director: filled in by the f	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.									or Towr	State)			al Route Numbe	ar, City	
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: Hos 24 h Fun etely		29a. Certifier 1 Certifying F	hysician:	To the best of	my knowle	edge, de	ath occur	red at the	time, da	te and pl	ace, and	due to the c	ause(s) and r	nanner :	as state	d.	
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, are and manner stated.																	
F 5 F 3	ž	29b. Signature and title of certifi	er	^				29c		e number				_		th, Day, Year)	
11		1 / Cul 1	20 D	(4)					O.C.1	И.E.			Septe	mber	26, 20	JUB	
		3 Name address of perso	n who com	npleted cause o	death (Ite				= 7/								
		Laron Locke MD.	Assistan	nt Medical E	xamine	r 11	1 Penn	Street,	Baltin	nore, N	1D 2120	01					
S	tate	31. Date filed (Month, Day Year 3200	0 1	32. Regist	6		. M -							-			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death OCTOBE L **Physician** 4:0064M /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) Examiner MONTGOMERY ROCKVILLE HEBREW HOME 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 NEW YORK 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1**X** M 2□ F FEB. 87 24,1921 Director 054-12-6758 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b County 28a-f show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Model Exercity for the 1.2 1 XYes 2 No Director MD. MONTGOMERY ROCKVILLE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death with 6111 MONTROSE RD. #608 20852 U.S.A. Funeral permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural" ~ " any lijury or other traumatic excent in the page. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ▼ No Specify Specify: ≥ 3 ☑ Widowed 4 ☐ Divorced Year or Dates: WHITE Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) ARCHITECT ARCHITECTURE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဥ JOSEF S. SMUL ETHEL LEBELL 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SILVER SPRING, MD. 20901 JULIA S. LENNEN/DAUGHTER 10823 MARGATE RD., 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 Cremation 3 ☐ Removal from State <sup>\*</sup>5 □Other (Specify) 10-6-2008 4 Donation CHAMBERS CREMATORY RIVERDALE, MD. 22. Name and Address of Facility CHAMBERS FUNERAL HOME & CREMATORIUM, P.A. 21. Signature of Funeral Se CLEVELAND AVE., RIVERDALE, MD. 20737 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown 1 🖺 Yes certificate has been s rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this e Hospital or Attending Phys 24 hours after death. 9 Funeral Director: After this letely filled in by the funeral di 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Wedical To the within 2. 29d. Date signed (Month, Day, Year)

OCTORER 09, 2008 29b. Signature a

State Registrar 31. Date filed (Month, Day, Year)
OCT 0 7 2008



		•	For State Registrar	State of Mi	aryland / D		ificate of L		a ivici	, ,	Reg. No.	2003	33574
_			1. Decedent's Name (First, Middle							Date of Dea Month	th Day	Year	3. Time of Death
	hysicia/ Medic/		Sally	Sr	nith					10/04/	2008	3	7:55 P <sup>M</sup>
` E	Examin	er	4a. Facility Name (If not institution	, give street and number)			4b. City, Town, or				4c.	County of Dea	th
			MANOR CARE P		//		If Under 1 Year	POTOMA(		Date of Dist			TGOMERY
	uneral rector		088-05-0777	6. Sex 7. Ag 1 ☐ M 2 🖾 F	e (In yrs. last birth	rs.	Months Days		fin.	Date of Birth (Month, Day 7 / 29 / 1	910	C	thplace (State or Foreign ountry) W YORK
and	M. I	1	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Loca	ation						10d. Inside City Limits
Maryl	fsho	Ď	MARYLAND MONTG	OMEDV	ROCKVI	TTT							1 ∑XYes 2 ☐ No
the	289	Director	10e. Street and Number	JEERI	KOCKVI	تا با با د	10f. Zip Code			1.	10g. Citi:	zen of What Co	ountry?
with	3a or		10301 GROSVENOR	PLACE, APT.	1903			20852				US	A
death	ms 2	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S.	13. W	as Decedent of H Yes, specify Cuba	ispanic Origin?	? (Specify	Yes or No-	Τ.	14. Race - Ame	
72 hours after death with the Maryland	ral", or items 23a or 28a-f show Examinat must be notified at	by	1 ☐ Never Married 2 ☐ Marri 3XX Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 1 ☐ Yes, Give Year or Dates:			Tes, specily Cuba	Specify:	uerto nic	ari, etc.)		Black, Whit	WHITE
72 hc	r than "natu the Medical	Completed	15. Decedent (Specify only highes	's Education t grade completed)		(Give k	ent's Usual Occup ind of work done o	during most of t	working		16b. Kir	nd of Business	/Industry
	than the the	ш	Elementary/Secondary (0-12)	College (1-4or 5	5+)		O NOT use retired TENOGRAP					T 17	CAT
filed within Hygiene.	other than vent, the W		12 17. Father's Name (First, Middle, I	(act)		3	TENUGRAP	18. Mother's N	Name (F	irst Middle	Maiden		GAL
l be fi	ed other event,	Be		Lasi)				"UNKNOW			7710.0017	0011101110)	
should I	mark	2	MORRIS HENDLER  19a. Informant's Name/Relationsh	nin /Type Print)	19h	Mailing	Address (Street			oute Numbe	r. City o	r Town, State.	Zip Code)
and 2 s	27 is		FRANCES TURNER,				HURDLE				-		
s 1 ar	item		20a. Method of Disposition		20b. Place of	Disposi	ition (Name of atory or other place	(90)	Date		20c. Lo	cation - City or	Town, State
t. Pages	Important: If item 27 is marked o any injury or other traumatic eve once.		Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)	pecify)	SHARON	I GA	RDENS	10		/2008		LHALLA,	
permi Depa	any Ir		21. Signature of Funeral Service	Licensee		DA 11	Name and Addres NZANSKY – 70 ROCK V	GOLDBEI	RG MI	EMORIA ROCKV	L CH	HAPELS, E, MARY	INC. LAND 20852
			23a. Part 1. Enter the disease, or shock, or heart failure. List	complications that caused	d the death. Do n	ot ente	r the mode of dyin	ng, such as car	diac or re	espiratory ar	rest,		Approximate Interval Between
Phy	sician		Immediate Cause (Final disease or condition	ASPERAT	CION PNEU	JMON	IA						Onset and Death  1 WEEK
	edical miner		resulting in death)		a consequence o								
LAG	illiilei	16	Sequentially list conditions,	D	FARCT DE		TIA						OLD
ted	nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury		SCLEROS IS								OLD
execu	n and al-tra	Examiner	that initiated events resulting in death) Last	C	a consequence o								OLD
tificate be executed	physician and the burial-transit			d									
rtifica	g g	/ledical	IE EEMALE.	1							$\top$		
Physician: The law requires that the death ce	by the attendir tached for use	Physician/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		e of pregnancy 2 ☐ Fetal death at time of death		Ectopic pregnanc Other (specify)	у			2	23d. Date of de Month	elivery Day Year
that	ed de		Part II. Other significant condition	ns contributing to death b	out not resulting in	the und	derlying cause give	en in Part I.		23e. Did to	bacco u	ise contribute t	o the cause of death?
quires	en sign ufd be	ed by								1 🗆 Y	es 2 <b>1</b>	∑No 3∏ F	robably 4 🗆 Unknown
aw re	s been s 2 should	Completed					*			24a. Was a		24b. Were a	utopsy findings available completion of cause of
The I	cate has page 2	mo							_	autop perfor	rmed?	death?	
lan:	certificate rector, pag	Be C	25. Was case referred to medical examiner?					26. Place of	Death (C				
hysic	dir is	To	1 Yes 2 XNo	Hospital: 1 ☐ Inpati	ent 2 ER/Out	tpatient		4 LINNUISIT	ng Home	5 ☐ Resid	ience (	6 □Other (Sp	ecify)
_ D	er		27. Manner of Death 1 ☑Natural 5 ☐ Pendin		ury 28b. T ay, Year) Ir	ime of njury	28c. Injur Worl		280	l. Describe h	ow injur	y occurred	
Attending r death.	tor:	icat	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could r	not be 280 Place of In	jury - At home, far	m stre		Yes 2 □ No	28f	Location /9	Street an	d Number or F	Rural Route Number,
tal or A	al Direc	Certification:	4 Homicide determ	building, et	tc. (Specify)	111, 011 0				City or Tow			
ie Hospit n 24 hour	To the Funeral Director: Aft completely filled in by the fun	Medical	29a. Certifier 1 ☐ Certifyir  (Check only 2 ☐ Medical one)	g Physician: To the best Examiner: On the basis of and manner st	of examination and	, death d/or inv	occurred at the tile estigation, in my c	me, date and p opinion, death o	olace, and occurred	d due to the at the time,	cause(s date and	) and manner a d place, and du	as stated. e to the cause(s)
To the	To the	M	29b. Signature and title of certifie	O DIO AX			29c. Licens D313					te signed (Mon DBER 5,	
3	(3)		, xull	MI Jone	17							,	
			30. Name and address of person DR • LORETO S • A					TE 305	, BE	THESDA	, MI	2081	4
F	Sta Registr		31. Date filed (Month, Day, Year)  OCT 0 7	2008 Regist	rar's Signature	bee	منا						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) FLORENCE **Physician** SMITH October 6, 2008 01:15 AM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Gaithersburg Wilson Health Care Center If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday, 5 Social Security Number **Funeral** Days Hours 1 □ M 2 🖾 F 84 531-20-6947 August 6,1924 Washington D.C. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 X Yes 2 □ No Director Rockville MD Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20854 United States 1990 Milboro Drive Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black White etc. 1 □ Never Married 2 □ Married White 1 ☐ Yes 2 No Specify Specify: altimore, Maryland 21215-0036 <u>ک</u> 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mabel Florence Sherwood Mortimer Buell Birdseye 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) Potomac, MD 20854 8905 Liberty Lane Michael A. Smith (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 10, 1 Burial 2 Cremation 3 Removal from State Oct. Silver Spring, MD Gate of Heaven Cem. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service Licensee CO. 10 East Deer Park Dr. Gaithersburg, MD 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CONS an week **Physician** 25 /Medical Due to (or as a consequence of) Examiner cay SCHRMIC if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): (Abivision or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Tes 2 No 3 Probably 4 Nonknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? 1 ☐ Yes 2 ☐ No 1☐ Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Hospital: Other: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 | Yes 2 No 2 ER/Outpatient 3 DOA 1 | Inpatient မ 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Manner of Death Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital the Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29h. Signature and title of certifier 29c. License number

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

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911

Registrar's Signature

d address of person who completed cause of death (Item 23a) (Type, Print)

Melnich

Year)

		Please	Type or Print in B				-		_			
		For State Registrar	,,,,,		rtificate of		,	Reg. No.	000	33576		
		1. Decedent's Name (First, Middle, La.	st)				2. Date of De	eath Day	y Year	3. Time of Death		
Physici /Medic		LILLIAN HENRIETTA	A SMALL				OCTOBE	R 5,	2008	1:00 P M		
Examin		4a. Facility Name (If not institution, giv 8101 CONNECTICUT		5		r Location of Death EVY CHASI	E	4c.	MONT(	th GOMERY		
Funeral		5. Social Security Number 6. S	Sex 7. Age (In yrs. la		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi	rth av. Year)	9. Biri	thplace (State or Foreign		
Director		579-60-9058 Usual Residence of Decedent	□ M 2X□ F 104	Yrs.	monard Days	110010	10/18/	1903		NEW YORK		
yland Jow		10a. State 10b. County	10c. City,	Town or Lo	ocation					10d. Inside City Limits		
with the Maryland a or 28a-f show be notified at	Director	MARYLAND MONTGON	1ERY CHE	VY CH						1 X Yes 2 No		
with th	Dire	10e. Street and Number	AMENTIE ADE 22	_	10f. Zip Code	20815		10g. Cit	izen of What Co US			
eath w rs 23a	Funeral	8101 CONNECTICUT  11. Marital Status	12. Was Decedent Ever in U.S		Was Decedent of H		ecify Yes or N	0-	14. Race - Ame			
72 hours after death with the Maryland natural", or items 23a or 28a-f show dieal Evandra must be notified at	þ	1 Never Married 2 Married  3 X Widowed 4 Divorced	Armed Forces? 1  ☐ Yes 2  ☐ No If Yes, Give Year or Dates:	i	If Yes, specify Cubate 1 □Yes 2 X No	dispanic Origin? (Span, Mexican, Puerto Specify:	Rican, etc.)		Black, White Specify:	e, etc. WHITE		
72 hours "natural"	etec	15. Decedent's Education (Specify only highest gradult)	ducation ade completed)	(Give	dent's Usual Occup	during most of work	ing	16b. K	ind of Business	/Industry		
han iệi	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	me.	DO NOT use retire	·			OWN I	HOME		
e filed within all Hygiene.	BeC	17. Father's Name (First, Middle, Last	)			18. Mother's Nam	e (First, Middle	e, Maiden	Surname)			
Menta	오	PHILLIP FRIEDLANI	DER			CARRIE						
and 2 sho ealth and n 27 Is m		19a. Informant's Name/Relationship (CAROLYN S. ALPER	, DAUGHTER	2700	VIRGINIA	AVE, NW	, WASHI	NGTO	N, D.C.	20037		
permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygie Important: If item 27 Is marked other traumatic event, Its any injury or other traumatic event, Its		20a. Method of Disposition 1፟፟፟፟⊠ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specia	Removal from State	emetery, cre	osition (Name of matory or other pla F REMEMBR		Date 07/2008		ocation - City or ARKSBUR	Town, State  G, MARYLAND		
Physician /Medical Examiner	ler	DANZANSKY-GOLDBERG MEMORIAL CHAPELS, 1170 ROCKVILLE PIKE, ROCKVILLE, MARY L  23a. Part 1. Enter the disease, or complications that caused to death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each limit limit disease or condition resulting in death)  PNEUMONIA  Due to (or as a consequence of):  PULMONARY FIBROSIS  Due to (or as a consequence of):										
rificate be executed ng physician and as the burial-transit	ledical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	ence of):								
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iclan: The certificate ector, pag	Be (	25. Was case referred to medical examiner?			1	26. Place of Dea						
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ding F h. After funera	tion:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year)	28b. Time o Injury	Wo	ry at rk? ]Yes 2 □ No	28d. Describe	now inju	ry occurred			
To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	De Diace of Injuny - At hou	me, farm, st				(Street a		iural Route Number,		
re Hospit 24 hours re Funera	Medical (	29a. Certifier 17 Certifying P (Check only one) 1 Medical Exa	hysician: To the best of my know miner: On the basis of examinat and manner stated.	wledge, dea tion and/or i	th occurred at the t nvestigation, in my	ime, date and place opinion, death occu	e, and due to the rred at the time	e cause( e, date an	s) and manner and place, and du	as stated. e to the cause(s)		
Withir Comp	Me	29b. Signature and title of certifier	HBen m	1		se number 3556			ate signed (Mon TOBER 6			
		30. Name and address of person who DR. ROBERT H. BL	EE, 5530 WISCON	SIN A		E 1400, CH	HEVY CH	ASE,	MARYLA	ND 20815		
Sta		31. Date filed (Month, Day, Year)	Registrar's Signat	-	a fine							

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State of Maryland / Department of Health and Mental Hygiene

UNK	1	- For State	State of	iviai yiai ia	Certifi	cate of	Death			R	Reg. No.			
Physicia	F	tegistrar 1. Decedent's Name	(First, Middle,Last)					4	2	Date of Dea Month	Day	Year		ime of Death
' Examir	ner	Misa	el Hern		Segura		b. City, Tow	or Locatio	n of Death	Septemb		County of		
		4a. Facility Name (if 4000 Blk. Dr	not institution, give str	reet and numbe	r)	4	Waldorf	i, or Locatio	in or beau			arles		
		5. Social Security Nu		7. F	ge (In yrs. last	birthday)	If Under 1		nder 24Hrs.	8. Date of B	irth(MM/DI	D/YYYY)	g. Birthpla Foreign	ice (State or
Funeral Director	1	None		2 F	50	Yrs.	Months	Days Ho	urs Min.	07/23	9/ I 9 .		Country	Guatemal
	ŀ	Usual Residence of				. 150							10	d. Inside City Limits
any any		Tour Otato	10b. County Charles		10c. City, To	wn or Locati Wal	dorf						13	X Yes 2 No
land f show	ō	MD					10f. Zip Co	ode			10g. Citize	en of Wh	at Country	?
Mary r 28a-	Director	10e. Street and Nun	65 Cotton	itop C	t			603				tema		
ith the 23a o	al D	11. Marital Status	1	2. Was Decede	ent Ever in U.S.	13. Wa	s Decedent es, specify (	of Hispanic	Origin? ( Sp	ecify Yes or I Rican, etc.)		14. Race W White		Indian, Black,
leath w	Funeral	1 Never Marrie	ed 2 X Married	Armed Force  1 Yes	2X No	1				emala	1	Specify:	Hisp	anic
after d	by F	3 Widowed	4 Divorced If		completed) 11	C- Decedo	atic Heusel Or	cupation (G	live kind of v	vork done			siness/Indu	
hours "natu!	ted	15. Decedent's Ed Elementary/Seco		College (1-4		during m	nost of working	ng life. DO N	NOT use retir	red)	Re	esta	uran	t
36 thin 72 than than edical	Completed	3 :						140.140	shar's Name	(First, Middl	e Maiden	Surname	)	
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MD 2 d 2 shoul lth and N n 27 is n	ľ	Ottonie	l Hernan	dez(SC	) N )					Date	20c	Location	- City or To	own, State
e, N 1 and 2 Health item		20a. Method of Dis	sposition Cremation 3	Removal from	20b. Pl	ace of Dispo ematory or o	osition (Name other place) Ceme	t or cemeter	y,    107	77/200				
Pages ent of unt: 16		4 Donation 5	5 Other Specify:		Ger			dalar an of F	o oilite/M o c	ron Fi	iner	al S	ervi	ce
Baltimore, MI permit. Pages 1 and 2 s Department of Health a Important: If iten 27 injury or other traum		21. Signature of F	uneral Service Licens	man and		5	801 (	leve	land	Ave	Rive:	raaı	е ш	20131
	_	23a, Part I. Enter	the disease, or compli	cations that car	used the death.	Do not enter	the mode of	dying, such	n as cardiac	or respiratory	arrest, sh	ock, or he	eart	Between Onset and
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Sox 68761 leath certificate e attending phy	ise as	past 12 mont	nths?	4 Pregn	ant at time of de	_	Other (Spe				_			
Box e death of the atter	for lord.	1 Yes 2		9 Olikilo	own death but not r	oculting in th	ne underlying	cause give	en in Part I.	23e.	Did tobacc	co use co	ntribute to	the cause of death?
P.O. es that the igned by		Part II. Other sig	gnificant conditions	contributing to	geath but not i	esularing in a	,o dinasinying	,		_ 1	Yes 2			
ls, P.C quires that en signed										24a.	Was an autopsy	241	prior to o	topsy findings available completion of cause of
Cord law red has be	2 should	ompleted								- 1 <b>V</b>	performed Yes 2		death? 1 ✔ Ye	es 2 No
Rec The	r, page	OF W/20 2000 FO	eferred to medical						Death (Che					
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Division tal or Attendirs after death.	filled in by	1 Natural 2 Acciden 3 Suicide 4 Homicio	determine	ed (Specify	Lake						own, State k. Drake			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Finnerial Director: After this certificate has been signed by the attending physician and	ly fille	4 Homicio	de	1-7- 2		edge, death o	occurred at the	ne time, date	e and place,	and due to the	ne cause(s	) and mar	ner as sta	ted. he cause(s)
To the H within 24	completely	29a. Certifier 1 (Check only one) 2	Certifying Physic  Medical Examina	er:On the basis and manner	of examination	and/or inves	stigation, in i	ny opinion, c		ed at the time				onth, Day, Year)
و الله الله	00	29b. Signature	and title of certifier				2	gc. License O.C.M			1		ber 26,	
2		Lame	W/ buth	all, N	20	am 22a)								
4.53		30. Name and	andress of person who E. Southall, MD	o completed ca Assistan	use of death (Ite t Medical Ex	aminer	111 Per	n Street,	Baltimor	e, MD 212	201			
					Registrar's Sign		,							
	9	AOT 5	(Month, Day Year)	Hanne	N 4									

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No .-1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 1553 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** mon HOSPITAL suburban Somers 5. Social Security Number 6. Sex Age (In yrs. last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** Months Days 1**X** M 2□ F Yrs 141-12-1980 82 Director Aug. 1926 New Jersey Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. Count 28a-f shov permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 273 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Medica Examina must be multified. 1 □Yes 2 No Director Maryland Montgomery Silver Spring 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 213 Stonington Road 20902 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. DOXYes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates WWII era 1 ☐ Yes 2 No Specify: þ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 5+ Structural Steel Engineer Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Irvin Tuttle Florence Webster 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marion Tuttle/Wife 213 Stonington Road, Silver Spring, MD 20902 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition October 9, 1 ☐ Burnial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Metropolitan Crematory 2008 Alexandria, Virginia 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc
500 University Blvd. W., Silver Spr Spring, MD 20901 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory ares, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of): Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) the 1 ☐ Yes 2 ☐ NO detached 9 Unknown 9 Unknown þ ۵. signed t Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ of Vital Records. 1 Yes 2 10 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 □ Natural 5 Pending investigation 13/08 1 ☐ Yes 2 ☐ ₩6 within 24 hours after death

To the Funeral Director:
completely filled in by the f 2 Decident from Roo 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rufal Route Number, City or Town, State) Silva 2/3 Stonington Roman determined 4 Homicide Silver Sprin Stoninston RD. Home 29a. Certifier 1 Cretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number မှ 3 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Said A. Daee, MD 8600 Old Georgetown Road, Bethesda, MD 20814 31. Date filed (Month, Day, Year) 3 Registrar's Signature State Registrar

lth d	eŗ	b per fd Pleas t 10/03/08 dl	State of Mar	yland / [	Departmen	t of F	Health and Me	ental Hy	giene	egibie.	
		For State Registrar			Certificate				Reg. No.	41111	3357
		1. Decedent's Name (First, Middle,	Last)					2. Date of De		Year	3. Time of Death
Physiciar /Medica		Joanne T. Tro	vato				S	eptem]	ber 2	27 2°0'(	08 3:40A
Examine		4a. Facility Name (If not institution,	give street and number)				r Location of Death			ounty of Dea	
		8358 Jumpers		<i>a</i> t 111			rsville	0. Data of Dir			rundel thplace (State or Fore
Funeral Director		094-26-9602	. Sex 7. Age (	(In yrs. last bir	Months	Days	Hours Min.	8. Date of Bir (Month, Da July	3 Year 93	35 N	ountry) York
A	- H	Usual Residence of Decedent  10a, State 10b, County	1	l 0c. City, Town	n or Location					_	10d. Inside City Lim
Hygiene "natural", or items 23a or 28a-f show ther than "natural", or items 23a or 28a-f show ant, I're Modreal Examiner must be notified at	į į	Taryland Anne	Arundel	Mil	lersvi	lle					1 □ Yes 2 <b>%</b> □I
or 28 e not	Jre P	10e. Street and Number			10f. Zip	Code			10g. Citize	en of What Co	ountry?
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al", or items 23a or 28a-f show Examiner must be notified at	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie	12. Was Decedent Eve Armed Forces? d 1 ☐ Yes 2 ☐ No				Hispanic Origin? (Spec an, Mexican, Puerto R	cify Yes or No lican, etc.)	D- 14	Race - Am Black, Whit	erican Indian, te, etc.
"natural", o	ğ	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 □ Yes 2	2 XNo	Specify:		S	pecify:	White
tedical	Completed	15. Decedent's (Specify only highest	Education grade completed)	16a	Decedent's Usua (Give kind of wor	l Occup k done	pation during most of working d)	g	16b. Kind	f of Business	/Industry
	E I	Elementary/Secondary (0-12)	College (1-4or 5+)		Bar 1				Capt	ain I	Bucks Bar
art'#		17. Father's Name (First, Middle, La	ust)		20.1		18. Mother's Name	(First, Middle			
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any injury or other traumatic event, the Monce.	Ĕ  .	19a. Informant's Name/Relationshi	(Type. Print)	19b	. Mailing Address	(Street	and Number or Rural			Town, State,	Zip Code)
r trai		Terence M. Tr		72	25 <b>01</b> d 1	Don	aldson Av	ve Se	evern	ı, Md	. 21144
othe	ŀ	20a. Method of Disposition		20b. Place o	f Disposition (Nam ry, crematory or of	ne of	(a) 10/0 <sup>p</sup>	ate/ 0.8	20c. Loca	ation - City or	Town, State
ry or		1 ☐ Burial 2 【X】Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		l .	o Cremat		i	·	Balt	imore	e, Md.
트	1	21. Signature of Funeral Service Li					S of city On S				
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		23a. Part 1. Enter the disease, or c shock, or heart failure. List or	omplications that caused th	ne death. Do					arrest,		Approximate Interval Between
cian		Immediate Cause (Final disease or condition	III ONE GAUSE ON CAN HITE.	129	0	2	nce				Onset and Death
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	Physician/Medical	IF FEMALE:	23c. If yes, outcome of	pregnancy					23	3d. Date of de	elivery
Tor use as the burial-transit	cia	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at ti		n 3 ☐ Ectopic p 5 ☐ Other (sp		су		20	Month	Day Year
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	S P	Part II. Other significant condition	s contributing to death but	not resulting in	n the underlying ca	ause giv	ven in Part I.	23e. Did	tobacco use	e contribute t	to the cause of death?
13	De de							1 1	Yes 2□	No 3∏ F	Probably 4 ☐ Unkno
3								24a. Was		24b. Were a	utopsy findings availa
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	Be C	25. Was case referred to medical					26. Place of Death				
		examiner? 1 ⊟ Yes No	Hospital: 1 ☐ Inpatient	t 2 ☐ ER/O	utpatient 3 DC	A Oth	ner: 4 ☐ Nursing Hom	ne Res	idence 6	□Other (Sp	ecify)
inneral unector, p	ij[	27. Manner of Death  Natural 5 ☐ Pending	28a. Date of Injury (Month, Day,		Time of 2 Injury	8c. Inju Wor	ry at 2	8d. Describe	how injury	occurred	
completely miled in by the lu	<u>ă</u>	2 ☐ Accident investiga			М		Yes 2 No	- 1			
·	Certification: Io	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		y - At home, fa <i>(Sp</i> ec <i>ify)</i>	arm, street, factory	office	2		(Street and wn, State)	Number or F	Rural Route Number,
d	3						1	4	1		
1	Medical	29a. Certifier Certifying (Check only one)  Check only 2 Medical E	Physician: To the best of kaminer: On the basis of e and manner state	examination ar	e, death occurred nd/or investigation	at the ti	ime, date and place, a opinion, death occurre	and due to the ed at the time	e cause(s) a , date and p	and manner a place, and du	as stated. ue to the cause(s)
	Med	29b. Signature and title of certifier	and manner state	•a.	4 290	Licens	se number		29d. Date	signed (Mor	oth, Day, Year)
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P	7	20 Name and address of name	he completed source of de-	ath (Itam 225)	(Type Drint)		1)36	J	40	100	120
y		30. Name and address of person w  GAY ATK  31. Date filed (Month, Day, Year)	and completed cause of dea	's Signatura	Cis.	かり.	1 30	57	tos	15	inie
State		OCT 0 3	2008 <b>State</b>	J Signature	breek	,		OV		,	
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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2101 1656 M Del Sie M -30 Immons Plember /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5A113644 HICIMICO REGIONAL If Under 1 Year | If Under 24 H/s. Age (In yrs. last birthday) Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗷 F Months Days Hours Min 214-32-5410 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Yes 2 □ No **Funeral Director** MD 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21811 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black Specify. þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Be T. mmons Spence 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) 8945 Lonshire md 218 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1,⊠Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility any is 7 WISE bellest - Salisbury, md 23a. Part 1. Enland disease, / complications that caused the shock, or heart failure. List only one cause on each line complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) JUNTOW W /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical the attending p use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 s autopsy 1 □Yes 1 Tes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 Yes 2 No 12 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 5 ☐ Residence 6 ☐ Other (Specify) 27 Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation I hours after death. uneral Director: A sly filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Eartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

Division of Vital Records, P.O. Box 68760, within 24 hours a To the Funeral C

145 32. Registrar's Signature 31. Date filed (Month, Day, Year) State OCT 0 2008 Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

(Check only one)

29b. Signature and title of certifie

29d. Date signed (Month, Day, Year)

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Division of Vital Records, P.O. Box 68760,

altimore, Maryland 21215-0036 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, Ira Ma once. Pages 1 Physician /Medical Examiner be executed and burial-trar attending physician for use as the burial signed by the a d be detached for cate has been signage 2 should b Hospital or Attending Physician: The 24 hours after death. Funeral Director: After this certificate hately filled in by the funeral director, page 24 hours a completely To the I within 2 To the I

**Funeral** 

Director

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23a

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"natural"

filed within 72 hours after

should be

traumatic event, the Medical Examiner must be notified at

State Registrar (Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Broad an Registrar's Signature 31. Date filed (Month, Day, Year)

and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Maryland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Gertember Day **Physician** 9:40 a M VADEN ELNORE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PRINCE GEORGE'S LANHAM DOCTOR'S HOSPITAL | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | APRIL 15 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗗 F MARYLAND Ĩ923 85 219-12-4452 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County tems 23a or 28a-f show ter must be notified at 1 Yes 2 □ No Director PRINCE GEORGE'S LANDOVER MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20785 2112 VERMONT AVENUE Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married permit. Pages 1 and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or it any Injury or other traumatic event, the Medical Examin any Injury or other traumatic event, the Medical Examin any Dince. **BLACK** Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: Š 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th College (1-4or 5+) HOUSE WIFE PRIVATE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LILLIAN MEDLEY **GEORGE** BLAKE ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7922 BEECHNUT ROAD CAPITOL HEIGHTS, MARYLAND 20743 GRACE HARRISON/SISTER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State WASHINGTON, DC MT. OLIVET CEMETERY 10/7/2008 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 21. Signature of Funeral Service Licensee 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** mo disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as a consequence offi Examine the HospItal or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical the attending pl 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) ☐Yes 2 No certificate has been signed by the rector, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy ENCEPha 1 ☐ Yes 2 No 1 ☐Yes 2 ₩No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar

29c. License number

29d. Date signed (Month, Day, Year,

and manner stated.

8118 Good Luck Rd. Carham, MD. 20706

Registrar

State

CHRISTA

31. Date filed (10th, 234, Year 2008

FISTLER

501 Scu 32. Registrar's Signature

South union Avenue, Havre de Grace, Mb 21078

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 205 **Physician** 4 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Washington Adventist Hospital TAkoma Park, Prince George's If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 6/25/1926 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🖾 F Days Hours Min. 82 Director 220-12-3528 VA Usual Residence of Decedent s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.

Item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, treative leads as in a range to recited as 1X Yes 2 □ No Director Prince George's MD Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3911 Oneida Place 20782 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ģ 1∐Yes 2⊠No Specify. White Specify: 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Telephone Operator Communications 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Walter C. Ellis ည Mary A. Ewers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Rhonda Keister/Daughter 4002 Oglethorpe St., Hyattsville, MD 20782 Pages 1 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages Department of Important; If Its any injury or o 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Cemetery 10/7/2008 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ft. Lincoln Funeral Home 3401 Bladensburg Rd. Brentwood, MD 20722 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner e Hospital or Attending Physician: The law requires that the death certificate be executed the hours after death. Funeral Director: After this certificate has been signed by the attending physician and letely filled in by the funeral director, page 2 should be detached for use as the burtal-transit Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑No 5 ☐ Other (specify) P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 **Division of Vital** 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 1 No 1 \_\_mpatient Medical Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 2 29b. Signature and title of certifier 29c. License number D0064024 person who completed cause of death (Item 23a) (Type, Print) 7600

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

LACHTCHININA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
State
Registrar/Amend#23a. Prt. ITPerPhys. PGC10-3-08cf ertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 0936 м **JOHN** LOUIS WHITE September 25, 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Medical Center Anne Arundel Annapolis If Under 1 Year | if Under 24 Hrs. Months Days Hours Min. 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 64 Yrs. Washington, DC May 13,1944 Director 578-58-6490 Usual Residence of Decedent 10c, City, Town or Location 10d. Inside City Limits 10b. County 28a-f show must be notifled at 1X Yes 2 □ No Director Washington District Of Columbia 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 6 USA 20011 Items 23a Funeral 5013 9th Street, NW 12. Was Decedent Ever in U.S. Armed Forces? 1963. 1 Ness 2 No If Yes, Give Year or Dates: 1969 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian. 11. Marital Status Black, White, etc 1 Never Married 2 Married African 'natural", or 1 ☐ Yes 2 No þ 3 ☐ Widowed 4 X Divorced American Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Government Police Detective Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Health and Mental Emmanual Mack White Douglas Marie 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Item 27 I 20721 1708 Bay Berry Terrace Bowie, MD Shawnda White (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any Injury or ot 1 X Buria! 2 ☐ Cremation 3 ☐ Removal from State Suitland, MD Lincoln Memorial Cem 10/2/08 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Jordan Funeral Service, Inc. 4001 Benning Road, NE Washington, DC TWA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner 1-4 Sequentially list conditions, if any, but on a bound cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of) physician Completed by Physician/Medical IF FEMALE: 23c, if yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension 1 TYes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ → 6 24a. Was an has autopsy certificate 25 Be 25. Was case referred to medical 26. Place of Death (Check only one 1 ☐ Yes 2 ☐ Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 patient 2 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation (Month, Day Year) Injury 1 ☐ Yes 2 ☐ No 2 Accident

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760 or Attending Physician: within 24 hours after ueau...

To the Funeral Director: Aft To the Hospital

with the Maryland

Pages 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

Medical Certification: 6 Could not be determined 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature dititle of ce 29c. License number 29d. Date sign d (Month, Day, Year)

00 30. Namerand completed cause of death (Item 23a

State Registrar 31. Date filed (Month, Day, Year) 3.2008

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		For State Registrar	Otate of Mary		Dertificate		2110 IV		g. No. 2	008	33586
Physicia	ın	1. Decedent's Name (First, Middle, La.	st)					2. Date of Death Month	Day	Year	3. Time of Death
/Medic	ai	Simmie Williams  4a. Facility Name (If not institution, giv	e street and number)		4h City Toy	wn, or Location of		October		2008 nty of Death	0725A M
Examin	er	Doctor's Communi				ham				-	eorge's
Funeral Director		3/9-42-3002	MM alle	yrs. last birth 38 Yı	Months   D	Year If Under Days Hours	24 Hrs. Min.	8. Date of Birth (Month, Day, May 10,	<sup>Year)</sup> 1920	9. Birthp Cour SC	place (State or Foreign ntry)
filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-1 show ont, the Modeal Evention counts be netfled at	Funeral Director	100. Street and Number  15005 Health Cer  11. Marital Status	George's I	Bowie	10f. Zip Co 207  13. Was Deceden If Yes, specify	716	igin? (Sp		U.S.	of What Cour	ean Indian,
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l within 72 giene. r than "na the Modic	Completed	(Specify only highest gra	College (1-4or 5+)		Give kind of work of life. DO NOT use r Lumber	done durina mos	t of work	ing	P1umb		,
2 should be filed and Mental Hyg Is marked other aumatic event,	To Be C	17. Father's Name (First, Middle, Last, Unknown						e (First, Middle, N Williams		name)	
and 2 sho lealth and m 27 Is ma her traums		19a. Informant's Name/Relationship (Gerald N. William		.11e,	MD 207	721					
15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. Do NOT use retired)  Plumbi  17. Father's Name (First, Middle, Last)  Unknown  19a. Informant's Name/Relationship (Type. Print)  Gerald N. Williams/Son  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, 3509 Sunflower Pl., Mitchellville, M  20a. Method of Disposition  18Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee  22. Name and Address of Facility  24. Juman  3401 Bladensburg Rd., Brentwood,											MD Home
Physician /Medical Examiner		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications the caused the one cause on each line.  a. Due to (or as a co	RAT	101	^					Approximate Interval Between Onset and Death
	dical Examiner	Sequentially list conditions, if any county county county county cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c								
The law requires that the death certificate be ate has been signed by the attending physicia age 2 should be detached for use as the but	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death	3 ☐ Ectopic preg 5 ☐ Other (spec		_		23d.	Date of deliv Month	ery Day Year
quires that n signed t	ğ	Part II. Other significant conditions of	contributing to death but no	ot resulting in t	he underlying caus	se given in Part I			acco use o s 2 □ N		he cause of death? bably 4 177 Unknown
The law requir te has been si age 2 should I	Completed	HYPE	RTEN	autopsy prior to completion of death?					ompletion of cause of		
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or Attending Physiclan: after death. Director: After this certific in by the funeral director; i	Certification: To	27. Manner of Death  1 Natural 5 Pending (Month, Day, Year)  28a. Date of Injury (Month, Day, Year)  28b. Time of Injury at Work?  M 1 Yes 2 No									al Route Number,
pital or ours afte reral Dir filled in	3 Suicide 4 Homicide  28e. Place of Injury - At home, farm, street, factory, office determined  28e. Place of Injury - At home, farm, street, factory, office City or Town, State)  28f. Location (Street and Number of City or Town, State)										stated.
To the Hos within 24 h To the Fun completely	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)									
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24		30. Name and address of person who			ype, Print)	elt so	B	erwirs	1 44	- M	3 20740

State Registrar 31. Date filed (Month, Day, Year)

OCT 0 7 2008



# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland   Per Stat	artment of Health and M 8 <b>dhb</b> <i>rtificate of Death</i>	lental Hyg	giene Reg. No. 2 1 1 8	33587
			Decedent's Name (First, Middle, Last)		2. Date of Dea	th _	3. Time of Death
	Physicia		Lincoln Wooten		Sept.	$3^{0}_{0}^{ay}$ , 200 $^{4}_{8}^{ar}$	9:05PM
and a second	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
أمس			Anne Arundel Medical Center	Annapolis		Anne Aru	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 🕅 M 2 🗆 F 7. F 7. T 7. T 8. Sex 9. T 9. T 9. T 9. T 9. T 9. T 9. T 9. T	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth	9. Birth	place (State or Foreign
	Director		2 2 4 - 5 2 - 6 2 2 5   TAJ M 2   7 5   Yrs.  Usual Residence of Decedent		10/10	7 1332	Texas
	yland yland at		10a. State 10b. County 10c. City, Town or Lo	ocation			10d. Inside City Limits
	Mar a-fsh ified	ctor	Md. Anne Arundel Annapol	is			1 X Yes 2 □ No
	th the or 28 e not	Director	10e. Street and Number	10f. Zip Code	1	10g. Citizen of What Cou	ntry?
	ath wist 23a	ral	20-B Amberstone Court	21403		USA	
	er dea items ner m	Funeral	Armed Forces?	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White,	
36	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or items 23a or 28a-f show ent, its Medicel Examiner must be notified at	by	1 ☐ Never Married 2 【 Married 1 【 Tyes 2 ☐ No If Yes, Give Year or Dates:	1 ☐ Yes 2 🛣 No Specify:		Specify: B	lack
21215-0036	2 hou	Completed		dent's Usual Occupation		16b. Kind of Business/Ir	ndustry
218	thin 7 e. an "n	nple	(Specify only highest grade completed) (Give life.	kind of work done during most of working NOT use retired)	ng		
	ed wi ygien yer th	Con		ne f		Federal Go	vernment_
and	be fill ntal H ed oth	Be	17. Father's Name (First, Middle, Last)  Nathenial Wooten	18. Mother's Name		мают Surname) lory	
롲	hould d Mei marke matic	ဥ		ng Address (Street and Number or Rura			in Code)
Maryland	id 2 sl Ith an 27 is i		, , ,	3 Amberstone Ct			
	t Hea f Hea item 2					20c. Location - City or T	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It. Medical Examiner must be notified at once.		Marylan	d Veterans: 10/0	8/08	Crownsvil	
aĦ	permit. Departm Importa any inju		21. Signature of Funeral Service Licensee	2. Name and Address of Facility B1	uford	Funeral S	ervice
<u> </u>	o a m co	6	Chrysle D Blufos 2 2	019 Martin Luth	er Kin	ig Ave., SE	,DC 20020
			23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one case in each line.	ter the mode of dying, such as cardiac of	or respiratory an	rest,	Approximate Interval Between Onset and Death
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and the	/Medical Examiner		resulting in death)		7		
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Box	leath certific attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 [	☐ Ectopic pregnancy		23d. Date of deli	very Day Year
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Vital Record	The law te has age 2 s	Completed	Hypertension	711	autop: perfor	med?   death?	ompletion of cause of 2 □No
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D C	ding Ph. h. After thi funeral (	:uo	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury	Work?	28d. Describe h	now injury occurred	
sio	ttend death tor: /	icati	2 Accident investigation 3 Suicide 6 Could not be 28a Place of Injury - At home farm str	M 1 ☐ Yes 2 ☐ No	20f Location (C	Street and Number or Du	ral Dauta Number
Division of	l or Attenk after death Director: I in by the	Certification:	4 Homicide determined determined 28e. Place of Injury - At home, farm, str	eet, lactory, office	City or Tow	Street and Number or Ru vn, State)	rai noute Number,
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	To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occurr	ed at the time,	date and place, and due	to the cause(s)
	Vithii withii Comp	ž	29b. Signature and title of certifier	29c. License number		29d. Date signed (Month	, Day, Year)
				1)00602	25	10/01/3	2008
	D 11		30. Name and address of person who completed cause of death (Item 23a) (Type,	· ·	0 1	14 200	20/01
	3B2		STEVEN HAMLETTE, M.D. 116 Def 31. Date filed (Month, Day, Year) 32. Registrar's Signature	ense Hwy. Suite 40	U Anna	polis, MD	20401
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Year **Physician** 2000 anc /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Deatl 4b. City, Town, or Location of Death Examiner Medical If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number Funeral Sex 1 M M 2 □ F Months Director Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10a. State 10b. Count s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene 1 hours after a 23a or 28a-f show lien 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, it is Marier Examinar must be retilled at other traumatic event, it is Marier in a must be retilled at 1 ☐Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 38 2 () Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No 1 ☐ Yes 2 If Yes, Give 1 Never Married 2 ☐ Married 1 □Yes 2 🗹 No Baltimore, Maryland 21215-0036 Specify. Black ş 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be heem ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Upper merboro, m) timer d 20c. Location - City or Town, State permit. Pages 1 a
Department of HeImportant: If Item
any injury or othe 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2XXCremation 3 ☐ Removal from State 10/6/2008 Atlantic Crematory Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Funeral Service Licensee 12 Ridgely Ave. Annapolis, MD 21401 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death 23a. Pan 1. Enter the disease, shock, or heart failure. Lis Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Exami and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Day Year Month 5 Other (specify) ☐Yes 2☐No is certificate has been signed by the director, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an was an autopsy performed?
Yes 2 No 2 No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes Certification: To After this 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death.

Funeral Director: A in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide fillec 🔝 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) within 2. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 00 30. Name and a res of person who complete is ause of death (Item 23a) (Type, Print)

Svzanne Rindflersch 2001 Med 2001 0CT 0 3 2008 31. Date filed (Month,

DHMH 17 Rev 1/2001

State Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 30 Year September 30 2008 Physician James Wallace 7:18A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 404 Chester Avenue Annapolis Anne Arundel 6 Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min 1 E M 2 □ F Director 216-14-5627 87 17 1921 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Im Medical Examinar must be netified at once. 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits **Funeral Director** 1 ☐¥Yes 2 ☐ No Maryland Anne Arundel <u>Annapolis</u> 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 404 Chester Avenue U<u>sa</u> 21403 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ∰Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Completed by Specify: 3 Widowed 4 □ Divorced Black TAT . TAT 11 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Laborer <u>US\_Naval Academy</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Abraham Wallace Eva Creek မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 623 Wye Island Ct. <u> Antoinette Wallace (Daughter)</u> Annapolis, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Rurial 2 ☐ Cremation 3 ☐ Removal from State 10/6/08 Bestgate Mem. Park Annapolis, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Wm. Reese & Sons Mortuary, 821 West St. Annapolis, Md 21. Signature of Funeral Service Licensee Wm. 821 1300xe 110048 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been sinned to the Amandian and the state of the funeral director. the burial-trar Due to (or as a consequence of) the attending physician ned for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) After this certificate has been signed by funeral director, page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Seridence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 atural 1 ☐Yes 2 ☐ No after death. 2 Accident the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 12 critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2008 Name and address of person who completed cause of death (Item 23a) (Type, Print) HwyStetto Annap MD Hamilton 116 Defence 31. Date filed (Month, Day, Year) egistrar's Signature State OCT 0 3 2008 Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Box 68760

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Division of Vital Records,

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Physicia dical Exami		1. Decedent's Name (First, Midd Lori Sue Well	S			<del></del>			2. Date of Month Octob	D	008	1049 hrs		
		4a. Facility Name (if not instituti 411 West Street	on, give street and nu	umber)	4	Berlin	wn, or Lo	ocation of De	eath		Worcester	ath		
Funeral Director	-	5. Social Security Number 212-82-6556	6. Sex	7. Age (In yrs. last	birthday) Yrs.	If Under Months	1 Year Days	If Under 24 Hours	Min.	of Birth (1	Fore	eign		
, any		Usual Residence of Decedent 10a. State 10b. County			own or Location	on			1			10d. Inside City Limits		
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the Mai a or 28	Director	411 West St.				i i	1811			1.09	USA	,		
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215-0036 be filed within 7 atal Hygiene. rked other than ent, the Medica	ошо	12 17. Father's Name (First, Middle	e Last)		Sa	les	18	Mother's N	ame (First, Mi	Idle Mai		ire		
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nore, MD 21215-0036 ages I and 2 should be filed within 72 hours after de nt of Health and Mental Hygiene. nt: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner m	To	19a. Informant's Name/Relation Kevin Wells							or Rural Rout in, MD		Ac. County of Death 1049 hrs    4c. County of Death   Worcester			
MOre, Pages I and nent of Healt and ant: If item or other trans	•	20a. Method of Disposition  1 Burial 2 X Crematic	on 3 Removal f	from State cre	ace of Dispos ematory or oth	ition (Name ner place)	of ceme	etery,	Date	ate 20c. Location - City or Town, State 10/08 Frankford, DE				
Baltimore permit. Pages 1 a Department of He Important: If it		4 Donation 5 Other S 21. Sign ture of Funeral Service		Caj	pe Hen									
<b>0</b> 8 2 5 E	-	21. Signéture of Funeral Service Licensee  22. Name and Address of Facility  108 William St., Berlin, MD 21811  23a. Fant I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart												
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Division of Vital Records, P.O. Box 68760, ospital or detailing Physician: The law requires that the death certificate be executed thours after death.  Incur Director: After this certificate has been signed by the attending physician and ly filled in by the funeral director, page 2 should be detached for use as the burial - transit	sician/Medical	IF FEMALE: 23b. Was decedent pregnant in past 12 months?  1 Yes 2 No 9 ✓ U	the 1 Live 4 Preg	, outcome of pregna birth gnant at time of deat	<sub>2</sub> Fe	tal death her (Specif	3 [ fy)	Ectopic pre	egnancy			•		
O. Be hat the desert by the setached for	Phy	Part II. Other significant cond	3 Oliki	nown to death but not res	ulting in the u	ınderlying c	cause giv	ven in Part I.	. 23e.	Did toba	acco use contribute	to the cause of death?		
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Division pital or Attendir ours after death. teral Director: A	Certification:		uld not be termined (Specify	ace of Injury - At hom  ()	ne, farm, stre	et, factory, o	office bu	iilding, etc.		ation (Str own, Sta		Rural Route Number, City		
To the Hosp within 24 ho To the Fune	ledical C	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the be	s of examination and	e, death occur d/or investiga	rred at the ti	ime, dat opinion,	e and place, death occur	, and due to the red at the time	e cause( , date ar	s) and manner as s nd place, and due to	stated. the cause(s)		
To wit To	Mec	29b. Signature and title of certif	and manner	stated.	4 Y	100		number			29d. Date signed (			
		flull c	On who consists on	use of death (Itam 3	( )		O.C.N	1.E.			October 8, 200	J8		
	1	30. Name and address of person	or write completed cal	use of death (frem 2	Jodj									

Russell Alexander MD.

111 Penn Street, Baltimore, MD 21201

OCME

Assistant Medical Examiner

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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			For State Registrar	State of Marylar	nd / Department of Certificate of			ene. 0 0 8	33591
	Physic /Medi Examir	cal	1. Decedent's Name (First, Middle, I Christian 4a. Facility Name (If not institution, g	Alexander	Wrlliams Ab. City, Town,	or Location of Death	2. Date of Death Month	Day Year 2-008 4c. County of Death	3. Time of Death
	Funeral Director		5. Social Security Number 6 N / A	Sex 12 F 7. Age (In yls.	last birthday) Yrs.  Li Under 1 Year Months Days		8. Date of Birth (Horth, Day, Y	Allega 9. Birth Cou	place (State or Foreign
Maryland 21215-0036	should be filed within 72 hours after death with the Maryland of Mental Hygiene. markad other than "natural", or Items 23a or 28a-f show matic event, Ite Medicul Exertiner must be notified at	To Be Completed by Funeral Director	Usual Residence of Decedent  10a. State  10b. County  10e. Street and Number  218 Mary La  11. Marital Status  1 Never Married  2 Married  3 Widowed 4 Divorced  15. Decedent's  (Specify only highest g  Elementary/Secondary (0-12)  0  17. Father's Name (First, Middle, La	qany U  nd Avenue  12. Was Decedent Ever in U Armed Forces?  1   Yes 2 K   No If Yes, Give Year or Dates:  Education rade completed)  College (1-4or 5+)  St)  William	If Yes, specify Cut  1  Yes 2 No  16a. Decedent's Usual Occu (Give kind of work done life. DO NOT use retire  Infant	pation of working most of working the latest the latest terms of t	city Yes or No-Rican, etc.)  16i  (First, Middle, Ma.	14. Race - Ameri Black, White, Specify: b. Kind of Business/In None	can Indian, etc. White ndustry
Baltimore, Mar	permit. Pages 1 and 2 should Department of Health and Men Important: If frem 27 is marka eny injury or other traumatic <u>pnce</u> .		19a. Informant Name/Relationship Kelli J. Stott /  20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spec	Mother  □Removal from State curify)	19b. Mailing Address (Street 218 Maryland Place of Disposition (Name of commeter), crematory or other pland Cremat 22. Name and Address 404 December 2404 December 25 December 26 December 26 December 27 December 27 December 28 December 28 December 29 December 29 December 29 December 29 December 29 December 29 December 20 December	Avenue, Cu	imberland /2008 Cu	, MD 2150 c. Location - City or Tourish	own, State  MD Home
1760,	Physician /Medical Examiner phe prize phe priz	icai Examiner	23a. Part T. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	y one cause on each line.	inence of):  un Aspnato	ng, such as cardiac of	zudoŝis		Approximate Interval Between Onset and Death
P.O. Box 68	ath certifica attending ph for use as ti	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 Live birth 2 Fete 4 Pregnant at time of d	ol death 3 Ectopic pregnance	у		23d. Date of delive	ery Day Year
Records, P.	w requires that the de been signed by the should be detached	þ	Part II. Other significant conditions	contributing to death but not res	ulting in the underlying cause gn	ven in Part I.	23e. Did tobac	co use contribute to to	he cause of death?
Vital Rec	ilcian: The law certificate has t rector, page 2 s	Be Completed	25. Was case referred to medical examiner?			26. Place of Death	24a. Was an autopsy performed 1 Yes 2 (Check only one)	prior to co death?	opsy findings available impletion of cause of
Division of V	Jing Phys	Certification; To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigate 3 Suicide 6 Could not	28a. Date of Injury (Month, Day Year)	28b. Time of Injury Wo	ry at 2 rk?  Yes 2 □ No	8d. Describe how i	e 6  □Other (Specifinjury occurred	
οį	To the Hospital or Attending within 24 hours after death. To the Funeral Director; After completely filled in by the fune		29a. Certifier 15 Certifying F	building, etc. (Specify hysician: To the best of my kno miner: On the basis of examina	y)	me, date and place, a	City or Town, S	e(s) and manner as s	tated.
	To the within 2 To the complete	Medical	29b. Signature and title of certifier  30. Name and address of person who	RAMESH VIDA	29c. Licens NF AVALUR MD.	se number 17 - 1215119	29d.	Date signed (Month,	Day, Year)
**	M ( ) Sta Registr			8 Registrar's Sign	600 Memoria	al Avenu	e, Cumb	verland, 1	nd 21502

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Y October 3, 2008 **Physician** 1:34 P Mary Jeanette Watkins /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner WMHS-Braddock Hospital Cumberland Allegany If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 X F 91 212-01-9819 March 12, 1917 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene. ant: If item 27 is marked to other than "natural", or items 23a or 28a-f show ant: If item 27 is marked other than "natural", or items 29a be notifiled at ury or other traumatic event, the Medical Examiner must be notifiled at 1 ☐ Yes 2 No Director Allegany Frostburg Maryland 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 16700 Mount Savage Road, N.W. 21532-U.S.A. Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) homemaker homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) To Be ( Robert Carder Virginia Long 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21502-Stanley E. Watkins, Sr. Maryland 452 N. Waverly Terrace Cumberland Department of Health Important: If Item 27 any Injury or other th once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c Location - City or Town State 1 Burial 2 □ Cremation 3 □ Removal from State October 07, 2008 Frostburg Memorial Park Frostburg Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service L 22. Name and Address of Facility John Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ling. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** day disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any localing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the as nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 🗷 No 4□Pregnant at time of death 9□Unknown Year Day 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Faillure ongestive 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown steo poro si 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy To the Hospital or Attending Physician: funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient | 2 | ER/Outpatient | 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural nours after death. neral Director: Af y filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year)

State

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Registrar

6 31. Date filed 2008

29b. Signature and title of certifier

Sandhir MD Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

48 Tarn Terrace Frostburg MD 21532

10.3.2008

# amended 10/14/08/items 10A,10B,10C,10E,10F/wchd/map Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Thomas Whittaker 2008 0500 M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HICOMICO REGIONAL 54413644 MOCKAL TENINSUM If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 □ F Months Days Hours 077-18-9226 84 7/24/1924 Director New Jersey Usual Residence of Decedent show 10d. Inside City Limits New York Putham Valaley Putnam ed other than "natural", or items 23a or 28a-f sho event, its Wedley Evaniant rust be redified at Director 1 X Yes 2 □ No Maryland Worcester Berlin with the 10e. Street and Number 392 Oscawana Lake Rd 7 Hatterhaus Street 10g. Citizen of What Country? 105**79** Funeral death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 14. Race - American Indian filed within 72 hours after I XYes 2 No.
If Yes, Give Air Force
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☑No Specify: <u>Ş</u> Specify: 3 Midowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Radio Announcer h and Mental Hygie Radio Broadcasting 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Thomas Whittaker Injury or other traumatic ပ Cecilia Whalen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 is any Injury or other trau orce. Christine Richmond/daughter 180 Pollard Hill Rd. Johnson City, New York 13790 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ferncliff Crematory 19/29/08 Hartsdale, New York 21. Signature of Funeral Service Lipenses 22. Name and Address of Facility
Holloway Funeral Home P.A.
501 Snow Hill Rd. Salisbury, Maryland 21804 Heth. alzena. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final INTRACEREBRAL **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** PTERIAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): certificate be executed and burial-trar Due to (or as a consequence of): Box 68760. attending physician Physician/Medical the asn 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy ρĮ in the past 12 months? 4 Pregnant at time of death Month 5 ☐ Other (specify) I ☐ Yes 2 ☐ No P.O. the detached 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, \$ 1 ☐ Yes 2 Î No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate of Vital 1 ☐ Yes 2 ☐ No 1 □Yes 2 □ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 **N**0 1 Yes 1 npatient Certification: To 2 ER/Outpatient 3 DOA this 27. Man or of Death 1 ✓ Natural ne Hospital or Attending P n 24 hours after death. ne Funeral Director; After t 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division 5 ☐ Pending investigation To the Hospital or Attendi within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) 29c. License number D0054048 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) nusless MD, Ph.D. September 96th, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) , 540 SNOW HILL ED, SAUSBURY MD 21804 CELL M. MALILL

State Registrar 31. Date filed (Month, Day, Year)

SEP 3 0

32. Registrar's Signature

**200**8

# **Physician** /Medical Examiner **Funeral** Director 28a-f show at Director notified Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be r Funeral Baltimore, Maryland 21215-0036 þ Completed 1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than ' Be 2 Pages 1 a Physician /Medical Examiner

3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Iona M. Whitley 4c. County of Death Facility Name (If not institution, give street and number) Town, or Location of Death Salisbur Wicomico If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Date of Birth (Month, Day, Year) 5. Social Security Numbe Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday Days 1 □ M 2 🕱 F 219-36-7147 1, 1926 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☑ No DF Sussex Delmar 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 36659 Robin Hood Road 19940 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ₹ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🖾 No Specify: 3 x Widowed 4 ☐ Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Teacher Elementary School 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lynn B. Marshall <u>Lydia Phillips</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alan Whitley (Son) 36659 Robin Hood Road Delmar, DE 19940 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4⊠Donation 5 ☐ Other (Specify) University of Delaware09-30-2008 | Newark, Delaware 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Short Funeral Home 13 E. Grove Street Delmar, DE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) END CARDIOMYOPATH STAGE Due to (or as a consequence of): ONGASTIVA if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner that the death certificate be executed and burial-trar Due to (or as a consequence of) Records, P.O. Box 68760, physician Physician/Medical the as attending IF FEMALE: for use 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) the 9□Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 21 No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an page 2 s nas autopsy performe certificate | Division or Vital Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🖾 🖁 o 14 Impatient 2 ER/Outpatient 3 DOA ٩ this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t Certification: the Hospital or Attending Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident death **Director**: filled in by the 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Dire Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. To the within 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0058410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) U BOP 1733 STOWS BUY NO 21802 CONSTAL WAR ( Atunton 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

DHMH 17 Rev 1/2001

Registrar

SEP 3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 33595 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Year JOHN FRANKLIN ZIMMERMAN 4:48 October 2008 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death HAGERSTOWN WASHINGTON COUNTY HOSPITAL WASHINGTON If Under 1 Year 9. Birthplace (State or Foreign Country) WEST VIRGINIA Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Days Months Hours 1 **№** M 2 🗆 F 219-82-7844 Director APRIL 8. 1961 Usual Residence of Decedent with the Maryland 10b. County 10c. City. Town or Location 10d. Inside City Limits show if than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 □Yes 2 No Director 28a-f MARYLAND WASHINGTON SHARPSBURG 10e, Street and Number 10f. Zin Code 10g. Citizen of What Country? "natural", or items 23a Funeral 3536 HARPERS FERRY ROAD 21782 Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☑ Never Married 2 ☐ Married 1 ∐Yes 2 No If Yes, Give X Year or Dates: Baltimore, Maryland 21215-0036 1 □Yes 2√√ No Specify. þ 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) of Health and Mental Hygiene. Item 27 is marked other than other traumatic event, Item III. College (1-4or 5+) DISABLED N/A17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be THOMAS JOHN ZIMMERMAN ၉ AUDREY MORGAN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3536 HARPERS FERRY ROAD, SHARPSBURG, MD <u>AUDREY J. SPIELMAN, MOTHER</u> 21782 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ot once. 1 Burial 2 □ Cremation 3 □ Removal from State SAMPLES MANOR CEMETERY 10/13/2008 4 ☐ Donation 5 ☐ Other (Specify) SHARPSBURG, MARYLAND 21. Signature of an all Service Licensee Bast-Stauffer Funeral Home, P.A. 7606 Old National Pike, Boonsboro, MD 23a. Part 1 I inter the disease, or complications that caused a shock for heart failure. List only one cause on each line. er complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 200 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 □ Yes 1 Ninpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

State Registrar

29b. Signature and title of certifier



completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Zimmerman Ruth 10 /Medical .08 0838 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Allegany
9. Birthplace (State or Foreign Country)
PA WMHS-Braddock Campus Cumberland Date of Birth (Month, Day, Year)
Mar 1, 1913 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** Days Hours Months Min. 95 Director 199-09-1961 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Exarting runt by mother at MD Allegany Cumberland Director 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21502 USA 15 Cumberland Street Funeral permit. Pages 1 and 2 should be filed within 72 hours after dea. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or item-20nce. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 □ N Specify ģ Specify: 3 Widowed 4 Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) teacher Board of Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Isadore Weiss Fannie Lindenbaum ္ရ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) MD 21502 Curtis Friedenberg 331 Sunset Drive Cumberland son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ ONemation 3 ☐ Removal from State Scarpelli Funeral Home, P.A. 10/2/2008 MD Cresaptown 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Scarpelli Funeral Home, PA 21. Signature of Functor Service Licenses 108 Virginia Avenue: Cumberland, MD 21502 23a. Pert 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedia Cause (Final disease condition resulting in death) Physician Due to (or as a consequence of): mass Cancer /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): the attending physician and hed for use as the burial-transit law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed been 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? certificate has Hospital or Attending Physician: The 2 No 2. No 1 □Yes 1 ☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA 2 this After thi 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation Natural 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director; A completely filled in by the ft. death. 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) worsockst MD 00055325 02.2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BISHOP WALSH RD cumberland MD 21502 n RS

State Registrar

31. Date filed (Month. Dav. Year) OCT 0 2 2008

WONSOCK SHIN

925 82. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 13, OCT. **Physician** Deborah Caro1 Andrews 2008 1:00 P.M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 35 Cobber Lane Baltimore City 8. Date of Birth (Month Day, Year) OCT • 7 • 1953 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Months Days Hours 1 □ M 2 🗓 F Maryland 213-64-4438 55 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 XiYes 2 □ No Director Maryland Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 35 Cobber Lane 21229 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 \( \text{Yes} \) 2 \( \text{N} \) No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2**X** If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2X No Specify: ģ White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Claim Authorizer Social Security Admin. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Carl Roscoe Andrews Sallie Sallie Elzevase ပ္ Bean 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janice Black (friend) 6737 Fox Meadow Rd. Baltimore, Maryland 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 X Removal from State Pisgah U.M. Church Cem 10/19/2008 Ashboro, North Carolina 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Sterling-Ashton-Schwab-Witzke Funeral Home, Inc.
1030Edmondson Ave. Catonsville, MD. 21228 21. Signature of Funeral Service Licen 140/490 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Arteriosclerotic Cardiovascular Disease months Due to (or as a consequence of): Sequentially list conditions, it cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 X No Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed 1 □Yes 2 □ No 1∐ Yes 2X No 25. Was case referred to medical Be 26. Place of Death Check onl one examiner? 1**X**] Yes Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work?

The law requires that the death certificate be executed physician and s the burial-trans as Jse for the g signed b

P.O. Box 68760,

Division or Vital Records,

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, <u>the Medical Examiner must be notified at</u>

of Health and Mental Hygiene.

permit. Pages 1 Department of H Important; If iter any Injury or oth

**Physician** 

/Medical

Examiner

72 hours after

Baltimore, Maryland 21215-0036

certificate l Certification: To this After

Hospital or Attending n 24 hours after death.

ne Funeral Director; A
bletely filled in by the ft death. Medical

To the Hosp within 24 hou To the Fune completely fi

27. Manner of Death 1 📉 Natural

2 Accident

4 Homicide

(Check only

3 ☐ Suicide

29a. Certifier

5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)

and manner stated.

28b. Time of Injury

1 ☐ Yes 2 ☐ No Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

ሺ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier MA

29c. License number Das 16934 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jayant R. Anjaria, M.D. 3100 Wyman Park Drive, Baltimore, Maryland 21211 ire Jack 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

2008 DHMH 17 Rev 1/2001

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiener (1)

			1 - State Registrar	<b>,</b>	C	ertifica	ate of D	eath	Re	eg. No.	33330
	Physici	an	1. Decedent's Name (First, Middle, La	ast)					2. Date of Death		3. Time of Death
	/Medic		Flarsha	All BYRD		- T			Cotober		3 6:23AM
	Examin	ier	4a. Facility Name (If not institution, gi					ocation of Death		4c. County of Dea	th
	Funeral		Haven Nursing H	Ome Sex 7. Age (In yrs. I	ast birthda	ay) If Und		If Under 24 Hrs.	8. Date of Birth	9. Bir	thplace (State or Foreign
	Director			12M 2□F 80	Yrs.	Month	ns Days	Hours Min.	8. Date of Birth (Month, Day, Oct 9,	1927 Mar	ountry) Tyland
	yland		10a. State 10b. County	10c. City	y, Town or	Location					10d. Inside City Limits
	a-fst	cto	MD	Вг	altim	ore					1√Yes 2□No
	h with the 23a or 28	al Director	10e. Street and Number 4718 Wakefield R	oad	-	10f. 7	Zip Code 212	16	10	0g. Citizen of What Co USA	ountry?
36	72 hours after death with the Maryland "natural", or items 23a or 28a-f show idical Exa ultur must be notified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☒ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ★ Yes 2 □ No If Yes, Give Year or Dates:	S. 1			panic Origin? (Sp Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify:	
00-	2 hour	ted	15. Decedent's E	Education			sual Occupation			16b. Kind of Business	/Industry
215	s 1 and 2 should be filed within 72 hc f Health and Mental Hygjene. item 27 is marked other than "natu other traumatic event, It is N. Alcal	Completed	(Specify only highest gr Elementary/Secondary (0-12)	rade completed)  College (1-4or 5+)	(Gi life	ive kind of to DO NOT	work done dur use retired)	ring most of work	ing		
7	ygien ygien er th	Con	unk t	unk						Naval Ac	ademy
gug.	ld be filk ental H ked oth Ic even	å	17. Father's Name (First, Middle, Las	t)			18			Maiden Surname)	
ryla	should be and Menta s marked umatic ev	은	Aaron Green  19a. Informant's Name/Relationship	(Time Brint)	10h Ma	siling Addre	on (Stroot on	Blanch		; City or Town, State,	Zin Cada)
Ma	nd 2 sho alth and 27 is ma r traum		Kelsir Byrd/brot			0			ield, VA		zip code)
Baltimore, Maryland 21215-0036	Pages 1 ar nent of Hea int: If item 3 iry or other		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	☐ Removal from State			lame of r other place)		-	20c. Location - City or	Town, State
Baltin	permit. Pages Department of Important: If i any Injury or once.		4 □ Donation 5 ☑ Other (Special Structure of Funeral Structure of Funer			22. Name State	and Address Anator	of Facility ny Board	655 W.	Baltimore	Street
	EB = # G		23a. Part 1. Enter the disease, or con	polications that caused the death	Do not 6	Balti	more, N	MD 2120	1 or respiratory arre	est	Approximate
	Physician /Medical Examiner	8	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	y one cause on each line.  a.  ue to lar as a consequ	ol	str	udi	. 1	lmaa	1	Approximate Interval Between Onset and Death
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consequ	ience of):	0	Del	- la	672	C - 1001	2
	certificate be executed nding physician and use as the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a consequ	ience of):	Cen	By	nece	1 18	cave	7
68760,	e be e			a Derz	a	re	7			/	
89	tificati g phy as the	Medical			in a Property						
ă.	death d for u	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnal 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of do 9 ☐ Unknown	death 3	3 □ Ectopio 5 □ Other	c pregnancy (specify)			23d. Date of de Month	elivery Day Year
ds, P.	The law requires that the diste has been signed by the page 2 should be detached	þ	Part II. Other significant conditions	contributing to death-but not resu	lting in the	underlying	g cause given	in Part I.		pacco use contribute to	o the cause of death?
00	w req	lete							24a. Was ar	n 24b. Were a	utopsy findings available
= Re		Completed							autopsy perform	y prior to ned? death?	completion of cause of s 2 □ No
Vita	iclan certifi ector,	Be	25. Was case referred to medical examiner?	Hospital:				6. Place of Death	(Check only one	e)	
on of	si si	ion: To	1  Yes 2  No  27. Manner of De th  1  Natural 5  Pending  2  Accident investigatio	28a. Date of Injury (Month, Day, Year)	ER/Outpat 28b. Time Injury	of	28c. Injury a Work?			ence 6 Other (Special of the Control	cify)
Division of Vital Records,	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	Accident investigation  3 □ Suicide 6 □ Could not be  4 □ Homicide determined	oe See Blace of Injury At hou	me, farm, s				28f. Location (Str City or Town	reet and Number or R n, State)	ural Route Number,
	To the Hospital or within 24 hours after to the Funeral Diructor Completely filled in I	edical C		hysician: To the best of my know miner: On the basis of examinat and manner stated.							
	To the within To the Comple	Me	29b. Signature and title of certifier	wrota mi		2	9c. License n	190	5 29	9d. Date signed (Mont	h, Day, Year)
			30. Name and address of person who AM-BACHEW	completed cause of death (Item	23a) (Type	e, Print)	MA	RYCAN	AVE,	BALTO	4/12/2/8
	Sta Registr		31. Date filed (Month-Pay, Year).	2008 32, Registrar's Signat	ure	house	3				

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of I	Marylan		artment of		and Me		giene 2 0	08	335	99
н			Decedent's Name (First, Middle,	Last)					2	. Date of Dea Month	ıth	V	3. Time of Dea	ath
	Physici /Medic		Anita Bickfor	d					0	ctober	17, 20	Year 08	7:25 AM	М
	Examir		4a. Facility Name (If not institution,				4b. City, Town		of Death		4c. County			
		AS.	8100 Connecti			1-11-11-1-1	Bethe		24 Hrs 0	. Date of Birth	Montg	•		
6.	Funeral		5. Social Security Number 055-10-5601	. Sex 7. 1 □ M 2 💢 F	Age (In yrs. 89	rast birtnday) Yrs.	Months Day		Min.	(Month, Day	r, Year)	Cour		oreign
	Director		Usual Residence of Decedent		09				D	ec 27,	1918	New	York	
	how at		10a. State 10b. County		10c. Cit	y, Town or Lo						1	10d. Inside City L	
	e Ma 3a-f s tiffied	Director	MD Montgon	ery		Bethe							1 □ Yes 2	INO
	filed within 72 hours after death with the Maryland Hyglene. ther than "natural", or items 23a or 28a-f show int, the Medical Examiner must be notified at		8100 Connecticu	t Avenue	#322		10f. Zip Code	0815			10g. Citizen of V USA		ntry'?	
	r deat	Funeral	11. Marital Status	12. Was Decede Armed Force	es?	.S. 13.	Was Decedent of If Yes, specify Co	f Hispanic Ori uban, Mexicar	igin? (Speci	fy Yes or No- can, etc.)	14. Rac Blac	e - Americ k, White,	can Indian, etc.	
36	ırs afte ıl", or it xamin	by Fi	1 Never Married 2 Marrie 3 X Widowed 4 Divorced	d 1 ☐ Yes 2 If Yes, Give Year or Date			1∐Yes 2 <b>∏</b> N	o Specify:			Specify	whi	te	
21215-0036	2 hou latura ical E	ted	15. Decedent's	Education		16a. Dece	dent's Usual Occ	supation	t of working	- 1	16b. Kind of Bu	ısiness/In	dustry	
218	thin 7 ie. ian "r Med	Completed	(Specify only highest Elementary/Secondary (0-12)	College (1-4 5+	or 5+)		kind of work dor DO NOT use reti	red)	i or working		1			
21	led will ygier lygier there there it, the		12			τ	eacher	10 Moths	orlo Mamo //	First Middle	educati Maiden Surnan			
and	d be fi ental F ced otl	o Be	17. Father's Name (First, Middle, La Sigmund B. Lau					Rose		iftel	waiten Suman	<i>(e)</i>		
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylar if Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	욘	19a. Informant's Name/Relationshi Brad Bickford/so				ng Address <i>(Stre</i> Utah Av					State, Zip		
Saltimore,	0 0		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3  4 ☒ Donation 5 ☐ Other (Sp.			Place of Dispo cemetery, cre	osition (Name of matory or other p	elace)	Dat	te	20c. Location -	City or To	own, State	
Balti	permit. Pag Department Important: I any Injury o		21. Signa are of Funeral Service Lonald	ensee Di	rector	1	2. Name and Add tate Ana altimore	•	oard 21201	655 W.	Baltim	ore S	Street	
	Physician	,	23a. Part1. Enter the disease, or or shock, or heart failure. List of Immediate Ca. (Final disease or condition	omplications that cau nly one cause on each	sed the deat th line.	h. Do not en	ter the mode of $C$	,	cardiac or		rest,		Approximate Interval Betwee Onset and Dea	en th
7	/Medical Examiner		resulting in death)	a. Due to (or	as a conseq	juence of):	Lan	21	1101	r		7	reaxs.	
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a conseq	juence of):	110/10	119			-	> 7	rears.	
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	al Examiner	cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or	as a conseq	uence of):								
9	tificate g physi as the	ledic												
P.O. Box	that the death certifice ned by the attending ph detached for use as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		h 2 ☐ Feta nt at time of d	al death 3[	⊒Ectopic pregna ⊒ Other <i>(specify)</i>		114			te of deliv	ery Day Yea	ır
	res that signed by be deta	by Pf	Part II. Other significant condition	s contributing to deat	th but not res	ulting in the u	inderlying cause	given in Part I	l.	23e. Did to	bacco use cont	ribute to t	the cause of deat	th?
Records,	w require been sig should b		_OSTEODO	20812						1 🗆 Y	′es 2⊠No	3 ☐ Proi	bably 4 □Unk	nown
၁၁ခ	law re as be 2 sho	Completed	anaem	9.						24a. Was	an 24b.	Were auto	opsy findings ava	ilable e of
R	'slclan: The law s certificate has t lirector, page 2 s	MO(	Failux	e lo	tho	ive.				perfo	rmed?	death?	2□ No	
/ita	clan: ertific	Be (	25. Was case referred to medical examiner?	11			1.		e of Death (	Check only o	ne)			
or o	Physician: r this certificaral director, I	မ	1 ☐ Yes 2 🔀 No 27. Manner of Death	Hospital: 1 Inp		ER/Outpatie	III JU DON				fence 6 Oth	- ' '	ify)	
on	ding P h. After funera	ion	1 Natural 5 Pending 2 Accident investiga	(Month,	Day Year)	Injury	V	vork? ∐Yes 2 ∐		id. Describe i	low injury occur	ieu.		
Division or Vital	al or Attendi after death. I Director: A d in by the fu	Certification:	3 Suicide 6 Could no 4 Homicide determin	t be 28e. Place of	f injury - At h	I ome, farm, st fy)	l reet, factory, offic		1	f. Location (S City or Tou	Street and Numb vn, State)	ner or Run	al Route Number	τ,
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical C		Physician: To the b xaminer: On the bas and manne	is of examina					d at the time,	date and place,	and due	to the cause(s)	
	To the vithin To the comple	Ž	29b. Signature and title of certifier	$\circ$			29c. Lice	ense number			29d. Date signe	d (Month,	, Day, Year)	
			1 7	uli'	_			146	04.		10.1	1-0	20	
-			30. Name and address of person w	TOWN!	ROAL	0,541	Print) RA.	MAN 2,GF	RITH	EULI,	MID LURGIY	カリン	0878	
	St: Regist	ate	31. Date filed (Month, Day, Year)	39	gistrar's Signa	ature	and I							

			For	State of Mar		Depa		lealth and	Mental Hy	giene	ible.	22500
	Physicia		State     Registrar     Decedent's Name (First, Middle,		M. BRAD		incate or i		2. Date of De Month	Day	Year	3. Time of Death 12:20 P M
سرمو	/Medic Examin		4a. Facility Name (If not institution, PEARTREE ASSISTE				4b. City, Town, or Pasadena			4c. County		
	Funeral Director		5. Social Security Number 212–10–4937	S. Sex 1 □ M 2 A F 7. Age (	(In yrs. last bi	rthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		ay, Year)	Coui	place (State or Foreign ntry) yland
	Maryland -f show	tor	Usual Residence of Decedent  10a. State  10b. County  Maryland Queen		Oc. City, Tow		cation				1	0d. Inside City Limits 1 ☐ Yes 2 🖺 No
	th with the 23a or 28s	al Director	10e. Street and Number  215 Green Stree		- OCH	<u> </u>	10f. Zip Code 21617			10g. Citizen of U.S		ntry?
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy fortury or other traumatic event, It. M. Jich Erani incrination political anonce.	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Marrie 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? d 1 ∐Yes 2 Manual No If Yes, Give Year or Dates:	er in U.S.	-	Was Decedent of H fYes, specify Cuba 1 □Yes 2 🕅 No	lispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	5- 14. Ra Bla Specia	ick, White,	can Indian, etc. uite
21215-0036	vithin 72 hor ene. than "natur	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	College (1-4or 5+)		(Give life. l	dent's Usual Occup kind of work done	during most of wo		16b. Kind of B		<sub>dustry</sub> istillery
and 2	ld be filed v ental Hygic ked other i ic event, ti	To Be Co	8 17. Father's Name (First, Middle, L. Walter		Mali		embly Lin ki		me (First, Middle	Calver , Maiden Surnai	me)	nknown
, Maryland	und 2 shoul alth and M 27 is mar er traumat		19a. Informant's Name/Relationshi Helen M. Baker	p (Type. Print)	19	b. Mailir	ng Address <i>(Street</i>	and Number or F	ural Route Numb	Maryla	nd_21	617
Baltimore,	Pages 1 a		20a. Method of Disposition  1 N Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Sp.	ecify)	20b. Place of cemeto	of Dispo ery, cren	sition (Name of natory or other place of Faith (	ce) Cem. 10/	Date	20c. Location Baltimo	- City or To	own, State
Ball	permit Depart Import any In		21. Signature of Funeral Service L	Collins	To the De	M.	Name and Address Name and Na	olyniák tain-Roa	d Pasado	na, Mar	.A. yland	21122 Approximate
1	Physician /Medical		23a. Part1 Enter the disease, or o shock, or heart failure. List o Immediate Cause (Final disease or condition resulting in death)	aue t (or as a	Ro	1	I A R	1 A	BL	) D(2)	EASE	Interval Between Onser and Death
	Examiner	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a	MI	74	HL H	YPE	RTE	MS10	N	30 YEAPS
,092	e be executed sician and burial-transit	cal Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a d	consequence	of):						
O. Box 68	The law requires that the death certificate be executed are has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ Mo 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	☐ Fetal deat		☐ Ectopic pregnand	су			ate of deliv	very Day Year
rds, P.	w requires that the de been signed by the should be detached i	by	Part II. Other significant condition	os contributing to death but	not resulting	in the u	nderlying cause giv	ren in Part I	4	tobacco use con		the cause of death?
Vital Records,	: The law re cate has be page 2 shd	Completed	SENIL	E DE	ME	2	TIA		24a. Was auto perf 1 ∐Yes	s an 24b opsy ormed? 2 2 No	Were aut prior to co death? 1 □ Yes	opsy findings available ompletion of cause of 2 🖾 No
	ding Physician: The n. After this certificate h funeral director, page	: To Be	25. Was case referred to medical examiner? 1 Yes 2 D No 27. Manner Death	Hospital: 1 ☐ Inpatien 28a. Date of Injury	28b.	Outpatie	nt 3 DOA Oth	ner: 4 🗆 Nursing		sidence 6 6 how injury occu	ther (Spec	ity)
Division of	Atten er deat ector: by the	Certification:	1 Natural 5 Pending 2 Accident investiga 3 Suicide 6 Could n 4 Homicide determin	ation of be 280 Place of Injury	y - At home, f	Injury farm, str	M 1 □	k? ]Yes 2□No		(Street and Num own, State)	nber or Rui	ral Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical Ce		g Physician: To the best of examiner: On the basis of eand manner state	examination a							
	To the within 2 To the comple	Me	29b. Signature and title of certifier	Jungt	M		29c. Licens	se number	600	29d. Date sign	_ ^	( - )

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10

Harjit Sihgn MD
31. Date filed (Month, Day, Year) 5410-A Ritchie Highway Brooklyn Park, Maryland 21225

State Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death Month 3. Time of Death Day **Physician BROWN** HESTER LOUVENIA **OCTOBER** 15, 2008 9:02 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SOUTHERN MARYLAND HOSPITAL CLINTON PRINCE GEORGE'S 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 1 ☐ M 2 **X** F Months Days Hours 245-18-6583 MAY 31, 1921 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director 1 ☐ Yes 2X No NC RUTHERFORD BOSTIC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? a

**Physician** /Medical

**Funeral** 

Director

ral", or items 23a or 28a-f show Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Examiner

or Attending Physician: The law requires that the death certificate be executed fler death.

Division of Vital Records, P.O. Box 68760

within 24 hours after death To the Funeral Director completely filled in by the

rai	898 ANDREW MILLS	ROAD		28018		U	USA				
Completed by Funeral D	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.: Armed Forces? 1	5. 1	13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 □ Yes 2 ☒ No Specify:			o- 14. Race - American Indian, Black, White, etc.  Specify: BLACK				
eted	15. Decedent's Ed (Specify only highest gra	lucation de completed)	(G	a. Decedent's Usual Occupation (Give kind of work done during most of working			16b. Kind of Business/Industry				
dmo	Elementary/Secondary (0-12)	life	life. DO NOT use retired)			DDIMARE					
Be Co	17. Father's Name (First, Middle, Last)		0031		18. Mother's Name (F		PRIVATE  Maiden Surname)				
To B	BUFORD HILL RHODA LOGAN										
-	19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)										
	HELEN BERTRAND / DAUGHTER 6111 WESSON DRIVE CAMP SPRINGS, MD 20746										
	20a. Method of Disposition  1 ABurlal 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  New Vernon Church Cem. 10-22-2008  BOSTIC, NC										
	21. Signature of Funeral Service Lidensee 22. Name and Address of Facility MARSHALL'S FUNERAL HOME OF MD										
	DONALD R. GRAY   4308 SUITLAND ROAD SUITLAND, MD 20746  23a. Part 1 / Enter the discase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot, or real failure. List only line cause on each line.  Approximate Interval Between										
	shoot, or beat failure. List only Immediat Calse (Final disease or indition resulting in death)	1 Accint	- ^ W	espiratory arrest,		Approximate Interval Between Onset and Death					
Jer.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying  Due to (/ as a consequence of).  Due to (/ as a consequence of).  Un Known  Due to (or as a consequence of):										
l Exami	cause. Enter Underlying Cause Circulate of April That initiated events resulting in death) Last  Due to (or as a consequence of):										
dica	_d										
Be Completed by Physician/Medical Examiner	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Ves = 27 No 9   Unknown   Unkno										
d by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1   Yes 2   No 3   Probably 4   Unknown										
etec	- June 1-4										
Comp			-			24a. Was an autopsy performed? 1 □ Yes 2	psy prior to completion of cause of				
Be	25. Was case referred to medical examiner?	Hospital: - 2			26. Place of Death (C	Check only one)					
2											
Medical Certification: To	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be										
Certifi	4 Homicide determined	building, etc. (Specify				City or Town, Sta					
edical	29a. Certifier  (Check only one)  1 Certifying Ph  1 Medical Exam	(Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)									
Σ	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  10.15.08										
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)										
e	31. Date filed (Month, Day, Year)	82, Registrar's Signat	ure	9801 50	8		- 1	1 10			
ar	OCT 2.2 2008	A 864 4 150	Service Services	A Comment of the Comm							

DHMH 17 Rev 1/2001

State

Registrar

OCT 2 2 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No./ 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day JANICE BULLOCK 10, MICHELLE OCTOBER 2008 9:58 Α /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPICE OF THE CHESAPEAKE LINTHINCUM ANNE ARUNDEL If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday, Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗓 F Yrs. Director 216-29-3731 NOV. 13, 1984 DC Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show the Medical Exeminar must be notified at Director PRINCE GEORGE'S OXON HILL 1 X Yes 2 □ No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Completed by Funeral 4924 WEADLING WAY 20745 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 ☐ Yes 2 XX If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: 3 Widowed 4 Divorced BLACK 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) PRINCE GEORGE'S Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any injury or other traumatic event, The Mental Injury or other traumatic event, The Mental Injury or other traumatic event, The Mental Injury or other traumatic event, The Mental Injury or other traumatic event, The Mental Injury or other traumatic event, The Mental Injury or other traumatic event, The Mental Injury or other traumatic event, The Mental Injury or other traumatic event, The Mental Injury or other traumatic event, The Mental Injury or other traumatic event, The Mental Injury or other traumatic event or other event or other eve College (1-4or 5+) TEACHER COUNTY PUBLIC SCHOOLS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be KEITH CARTER BARBARA BULLOCK ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHERITA PHILLIP / SISTER 16338 ELKHORN LANE BOWIE, MD 20716 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HARMONY MEMORIAL PARK 10-17-2008 LANDOVER, MD 21. Si nature 22. Name and Address of Facility MARSHALL'S FUNERAL HOME OF MD DONALD R. GRAY 4308 SUITLAND ROAD SUITLAND, MD 20746 23a. Part 1. Et if the disease, or or plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock. If near failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or or ndition resulting in death) **Physician** SACRAL SARCOMA /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and/ Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) ☐Yes 2☐No ed by the detached 9 Unknown ate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ WILM'S TUMOR 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 X No 1 □ Yes 2 🗆 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) HOSPICE Other: 4 Nursing Home 5 Residence 6 X Other (Specify) 1 Tes 2 No 1 ☐ Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) HOUSE 27. Manner of Death 28b. Time of After 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 □ No within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated ca 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

NIMMAGADDA GAYATRI

2008

31. Date filed (Month, Day, Year)

OCT 22

01

305 HOSPITAL DRIVE GLEN BURNIE, MD 21061

00

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** BYWATERS 1041A M 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** BACITMORE MEDICAL CENTER f Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 04/02/1927 Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F Months Days Hours Min 81 219-22-1670 Maryland Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show rust be notified at Director 1 ☐ Yes 2√☐ No MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5923 Franklin Avenue 21207 Funeral United States death items 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian permit. Pages 1 and 2 should be filed within 72 hours after de Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, Itu Medical Experience. Marined Forces

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Zero Pares

Marined Forces

Zero Pares

Marined Forces 1 ☐ Never Married 2 ☐ Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. White þ 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Marine Maintenance Supervisor Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Paul C. Bywaters Dorothy Compton ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Pallay (Daughter) 2508 Braddock Road, Mount Airy, Maryland 21771 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🗷 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crest Lawn Cemetery 10/18/2008 Marriottsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. Made T 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease percomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** MASSIVE MELCLANTAL 6 HOURS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed Ag B as the burial-trar Due to (or as a consequence of): Box 68760, the attending physician Physician/Medical IF FEMALE: for use If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) P.0. detached 9 I Unknown 9 Unknown þ signed l 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, δ. 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed has been 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? certificate **Division of Vital** 2 X No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Certification: 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier (Check only one) and manner stated 29b. Signature and the of certifier 29c. License number 29d. Date signed (Month, Day, Year)

841

State Registrar BELLAL JOSEPH 2
31. Date filed (Month, Day, Year) 32. Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

ENE

ST BAGTMORE MD 21201

#30 per DVR g884 10/22/08 TT Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** OCTOBER 18, ROSLYN L. BARISH 2008 12:35 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOLY CROSS HOSPITAL SILVER SPRING MONTGOMERY If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 10/17/1915 Birthplace (State or Foreign Country) **Funeral** Months 063-07-5116 93 1 □ M 2 💢 F NY Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or Items 23a or 28a-f show the Medical Examinar must be notified at Director MD MONTGOMERY SILVER SPRING 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14508 HOMECREST ROAD, #419 20906 **USA** by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Item any Injury or other traumatic event, the Medical Examina once. 1 Never Married 2 Married Specify: WHITE 1 ☐ Yes 2 No Specify. 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SECRETARY FURNITURE 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be LEVINE ROTNER HARRY EVA မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ELAINE ECKSTEIN / DAUGHTER 9447 COMMON BROOK RD., APT.404 OWINGS MILLS 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State BETH EL CEMETERY 10/19/2008 PARAMUS, NJ 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ENCEPHALOPATHY /Medical Due to (or as a consequence of):
TRANSIENT ESCHEMIC ATTACKS Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ATRIAL FIBRILLATION Examine signed by the attending physician and I be detached for use as the burial-trar Due to (or as a consequence of): URINARY TRACT INFECTION Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Unknown 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No this certificate 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2**X** № Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 28b. Time of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

State

(Check only one) 29b. Signature and title

31. Date filed (Month,

of certifier

Day toan 2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008 32. Registrar's Signature

with the Maryland

altimore, Maryland 21215-0036

death certificate be executed

The law requires that

Attending Physician:

P.O. Box 68760,

Division of Vital Records,

Adaku Chimtua Onukogu, MD 1500 Forest Glea Rd Silver Spring, MD 20910

29c. License number

D65953

29d. Date signed (Month, Day, Year)

10/18/2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 📿 🛛 🗍 🥱 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Ye ar **Physician** 2008 **BLOOM** 08:53P M SARAH CLOBER /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MALTIMORE N/A HOSPITAL OF POMITIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 06/10/1920 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) POLAND **Funeral** 1 □ M 2 💆 F Days 213-01-6552 88 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f show 7 is marked only than "natural", or items 23a or 28a-f shov traumatic event, the Modeal Examiner is sat be nothed as 1 □Yes 2 No Director BALTIMORE BALTIMORE MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21208 218 CHURCH LANE Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married WHITE Baltimore, Maryland 21215-0036 1 □Yes 2 🛣 No Specify. Specify: δ 3 X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any Injury or other traumatic event." Elementary/Secondary (0-12) College (1-4or 5+) AGENT REAL ESTATE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LEVIN IDA SAMUEL ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) ARLENE ROSENBERG / DAUGHTER 218 CHURCH LANE, BALTIMORE, 20b. Place of Disposition (Name of SLI PRINTED FOR EXAMPLE OF SUCCESSION 20c. Location - City or Town, State 20a. Method of Disposition 1 A Burial 2 Cremation 3 Removal from State 10/20/2008 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** DAY disease or condition resulting in death) /Medical Due to (or as a consequence of): OBSTRUCTION **Examiner** TRIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) or Attending Physician; The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760. Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 Other (specify) P.O. sbeen signed by the should be detached 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ð MYG2010 LEUKEMIA 2 No 3 Probably 4 Unknown 1 Tes Be Completed UI MONARY 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b irector, page 2 sh autopsy performe 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending To the Hospital or Attendia within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1214

12

KNOWN

State Registrar

ate 31. Date filed (Month, Day, Year)

OHIT MS/S S 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SINAI HOSPITAL

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of Maryland				Mental Hy	giene	ŭ	
			Registrar  1. Decedent's Name (First, Middle, La		Ce	rtificate of l	Death 	2. Date of De	Reg. No.	2008	3.3360
	Physicia /Medic		Gloria	Jean		Carter		October		2008 <sup>ar</sup>	11:54 a <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, gi Frederick Memo			4b. City, Town, or Frede	r Location of Death crick			county of Death rederic	
ı	Funeral Director		5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)  1 Months  1 Days  1								
e, Mai yiali	Maryland a-f show	tor	10a. State 10b. County		Town or Lo	ecation RICK					10d. Inside City Limits
	th with the 23a or 28	Funeral Director	10e. Street and Number 476 CARROLG	ON DRIVE		10f. Zip Code	1701			en of What Cou	ntry?
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatly and Mental Hygiene. Department of Heatly and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatte event, the Medical Examinar must be notified at once.	þ	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Tovorced	12. Was Decedent Ever in U.S Armed Forces? 1 Tes 2 No If Yes, Give Year or Dates:	- 1	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☐ No	dispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No Pican, etc.)		4. Race - Ameri Black, White,	etc.
	id within 72 h rgiene. er than "natu , the Madien!	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed)  College (1-4or 5+)	(Give life.	edent's Usual Occup kind of work done DO NOT use retired	during most of world)	king		of Business/Ir	
	2 should be filed with and Mental Hygiene is marked other that raumatic event, the N	To Be (		POLLARD			18. Mother's Nam				
	1 and 2 sho Health and em 27 is m wher traums		19a. Informant's Name/Relationship CHARUES R. T	Hompson 3rd	1837	ng Address (Street	S DIZ. H.	AGGRST	TOWN	IMD	21740
	permit. Pages 1 Department of H Important: If itel any injury or ott		20a. Method of Disposition  1. □ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Spec	Removal from State	THAY	osition (Name of matory or other place NEN MGM	1. OCT 2	Date 21, 2008	FRE		k mp
סמ	permit Depart Import any inj once.		21. Signature of Funeral Service Lice	Rollis		2. Name and Addre					
) )	Physician /Medical		23a. Part1. Enter the displace, or cor shock, or heart fature. List only Immediate Cause (Final disease or condition resulting in death)	nplications that caused the death y one cause on each line.  Arteriosc  Due to (or as a consequ	lerot						Approximate Interval Between Onset and Death Years
	Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury								
9, 00	cate be executed bhysician and the burial-transit	Examiner	resulting in death) Last  Due to (or as a consequence of):								
-	tificate b ig physic as the bu	ledica	•	d							
al necolus, r.o. box	the death cer y the attendir ched for use	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1   I ive hirth 2   Fetal death 3   Fetanic pregnancy						3d. Date of deli Month	very Day Year
	juires that n signed b ild be deta	by	Part II. Other significant conditions	contributing to death but not resu	llting in the u	underlying cause giv	en in Part I.				the cause of death?
	:: The law red cate has bee ; page 2 shou	Completed						24a. Was auto perfo 1 □Yes	psy ormed?		copsy findings available ompletion of cause of
	to the hospital or Attending Priystcant. The law requires that the beatt Certifical within 24 burst after deep 4. After this certificate has been signed by the attending placement. To the Fuhards Director. After this certificate has been signed by the attending placement of the funeral director, page 2 should be detached for use as to completely filled in by the funeral director, page 2 should be detached for use as to completely filled in by the funeral director.	Be	25. Was case referred to medical examiner?	Hospital:		Oth	26. Place of Dea	,			
INISIOI OI		ion: To	1 X Yes 2 □ No  27. Manner of Death 1 X Natural 5 □ Pending	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	of 28c. Inju	4 LI Nursing H	ome 5 ☐ Resi 28d. Describe			ify)
	I or Attendation after death	Certification:	2 Could not be						Street and Number or Rural Route Number, wn, State)		
	e Hospita 24 hours e Funeral letely fille	edical C	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	To th withir To th comp	Me	29b. Signature and title of certifier  D37197  29d. Date signed (Month, Day, Year)  October 15, 2008								-
-	3		30. Name and address of person who Alan H. Rohrer,	D.M.E., 15 Wes	t Sev	enth Stre	et, Frede	erick, N	ary1	and 217	01-4501
			31 Date filed (Month Play Nearly	32. Registrar Signal	46	-					

Registrar

DHMH 17 Rev 1/2001

### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene [] [] 8 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 10 Day U8 **Physician** 1645 ANA WILLIAM UNNINGHAM /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Mandrin Hospice House Harwood Anne Arunde! If Under 24 Hrs. Hours Min. If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months 1 M 2□F 53 Director 214-54-9788 Feb 23, 1955 Washington DC Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours efter deeth with the Maryland neet of Health and Mentel Hygiene. and it If I few 27 Is marked other than "netural", or items 23s or 28s-f show that I few 197 Is marked other than "netural", or other traumatic event, The Medical Evaninar must be notified at any or other traumatic event, The Medical Evaninar must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "netural", or items 23a or 28a-f show the Medical Examiner must be notified at MD 1 ☐ Yes 2√ No Anne Arundel Annapolis Directo 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code 7 Dorchester Drive 21403 **IISA** Funerai 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: white þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) marketing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Owen Edward Cunningham Edna Lee Hall 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mandrin Hospice House 3675 Solomons Island Road Harwood, MD 20776 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Depertment of Important: If any injury or once. 4 ☑ Donation 5 ☐ Other-(Specify) 21. Signature of Funeral Service Lice State Anatomy Board 655 W. Baltimore Street Director 0 Baltimore, MD 21201 Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Phytician /Medical Immediate Cause (Final disease or condition resulting in death) 20 Examiner Due to (or as a consequence of) Examiner ettending physician end for use as the buriel-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? ate has been signed by the page 2 should be deteched Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 ☐ Yes 2 ☐ No 1 ☐ Yes eral Director: After this certification in by the funeral director. To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 🗆 Inpatient 2 ER/Outpatient 3 DOA HOSPILE . Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \( \text{Homicide} \) within 24 hours e To the Funeral C completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 0 214 3 8 29b. Signature and title & certifier Name and address of person who completed cause of death (Item 23a) (Type, Print)

11 11 AD THE WAY 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 22 OCT 2008

Registrar

Baltimore, Marvland 21215-0020

The law requires that the death certificate be executed

certificate has

To the Hospital or Attending Physician:

death.

Division of Vital Records, P.O. Box 68760,

1 - For State Registrar

		1. Decedent's Name (First, Middle, La	st)				2. Date of Dea Month		Varia	3. Time of	Death	
Physicia		ELVA E.	CATTERTON				October	r 20, 20	08	4:54	$A^{M}$	
/Medic Examin		4a. Facility Name (If not institution, giv			4b. City, Town, or Location of Death		ath	4c. County			-	
Examin	Ç.	8293 Pond Court	· ·			lersvill		Anne		_1		
Funeral		5. Social Security Number 6. 8		ast birthday							r Foreian	
Funeral Director			I□M 2⊠F	Yrs.	Months Days	Hours Mir	. (Month, Day			ace (State of	, , oreign	
Director		218–18–0089 Usual Residence of Decedent	93				Feb. 27	, 1915	Maryl	and		
and w		10a. State 10b. County	10c. City	, Town or Le	ocation				10	d. Inside Cit	ty Limits	
faryl sho	ō									1 □ Yes	2 <b>X</b> No	
Ne N	ect	Maryland Anne Ar	<u>undel</u>	Pasa	adena							
ith t	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citizen of W	/hat Countr	ry?		
23a		_357 San Gria Cou	rt			21122		USA				
ours after death with the Marylan rai", or items 23a or 28a-f show		11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	3. 13.	Was Decedent of H	dispanic Origin?	Specify Yes or No-	14. Race	e - America k. White, et			
afte or it	Ē	1 ☐ Never Married 2 ☐ Married	1 □Yes 2 ▼No If Yes, Give	1 ☐ Yes 2 ☑ No Specify:			, , , , , , , , , , , , , , , , , , , ,		· .	White		
filed within 72 hours after death with the Maryland Hygiene. Hygiene, with atten "natural", or items 23a or 28a-f show ant, the investigal Exar, incl. ust be notified at	l by	3 ☑ Widowed 4 ☐ Divorced Year or Dates:			TENES ZEGINO	Specify	· wn	ıte				
72 hc	Completed	15. Decedent's E (Specify only highest gra	16a. Dece	edent's Usual Occup e kind of work done	pation	16b. Kind of Bu	6b. Kind of Business/Industry					
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and Healther					San Gria					1122		
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permit. Pages 1 and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural"; or i any Injury or other traumatic event, I'm Medical Even.		21. Signature of Funeral Service Lice	nsee	2	22. Name and Addre	ess of Facility						
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Physician /Medical		disease or condition resulting in death) a. ANDREXICA								3 mor	14hs	
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and A GOL	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a conseque									
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dea death	ici	in the past 12 months? 1 ☐ Yes 2 🗷 No	4 ☐ Pregnant at time of de		Other (specify) _	-y		Mo	nth [	Day Y	Year	
w requires that the dispension is been signed by the should be detached	Physi	9 Unknown	9 Unknown									
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i: The	9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I.  24e. Was an autopsy performed? 1   Yes   2   No    24e. Was an autopsy performed? 1   Yes   2   No    25e. Was case referred to medical examiner?  1   Yes   2   No    26e. Place of Death (Check only one)  27. Manner of Death   1   Nother investigation   1   Nother investigation   1   Yes   2   No    27. Manner of Death   1   Nother investigation   1   Yes   2   No    28e. Place of Injury   28e. Injury at Work?   1   Yes   2   No    29e. Certifier   Check only one)  29e. Certifier   29e. Certifier   29e. Certifier   29e. Certifier   29e. License number   29e. Date signor and manner stated.									Yes 2 No		
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To the Hospital or Attendal within 24 hours after death. To the Funeral Director: A completely filled in by the fu	ğ	29b. Signature and title of certifier	() - ~		29c. Licens	se number		29d. Date signed (Month, Day, Year)				
		Maney DR	- King M. I	).	Dog	40904		OCTURS 21 2008				
1		30. Name and address of person who	completed cause of death (Item	23a) (Type		, , , ,			t	1	)	
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Sta	te.	31. Date filed (Month, Day, Year)	32 Registrar's Signati	ure	5 ws	vaca m	VICA FVI	IIMPER	III	3170	ر با	
'Registr		OCT 2 2 21	108 1000 1	( A	19423							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 🤈

State of Maryland / Department of Health and Mental Hygiene 33609 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2008 Year **Physician** LOVINE CLARKE 1:00 P M October 18, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Towson Baltimore Gilchrist Center for Hospice Care 8. Date of Birth (Month, Day, Year)
Aug. 13, 1 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 1 □ M 2 🕅 F Months Days Hours Min. 219-32-1999 73 1935 Pennsylvania Director Aug. Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any inJuy or other traumatic event, I'm Medical Examinar must be nothed as 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits Baltimore N/A Director Marvland 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? 21225 1023 Jack Place USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Specify: Be Completed by 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Housewife & Mother Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charles Ellsworth McKnight Margaret Grace Evans ို 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marion M. Megibow 51 Powder View Court, Nottingham, Md. (Daughter) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Mem. Pk. 10/22/08 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Kevin E Ecker McCully-Polyniak Funeral Home,P.A. 237 E. Patapsco Ave., Balto., Md. 21225-1856 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** a ACUTE MYOCARDIAL INFARCTION DAYS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner PULMONARY EMECLI WEEKS Se prentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine law requires that the death certificate be executed the burial-transit L Page NON-SMALL CELLUNICANG Due to (or as a consequence of): attending physician Physician/Medical for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown funeral director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by GASTROINTESTINAL BLEEDING Records, 1 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No Physician; The Vital 2 No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending Division 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie OCTOBER 18, 2008 D64395 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMINE, MO 21204 SUITE 209 DANIENE DOBERMAN, MO 6565 NCHAPLES ST, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

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Director

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Examiner

Physician/Medical

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Certification: To

Medical

29a. Certifier

(Check only

29b. Signature and title of certifier

Certificate of Death

**Physician** /Medical Examiner

**Funeral** Director show

should be filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shot any injury or other traumatic event, the Medical Examinant, ust by nothing any

altimore, Maryland 21215-0036

**Physician** /Medical Examiner

burial-trar physician at the burial-Division of Vital Records, P.O. Box 68760 ed by the attending p detached for use as signed by t certificate has this To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A filled in by

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year October 18, 2008 5:33 PM Florence Chang 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Montgomery Rockville If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 05/03/1919 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days Min. Months Hours 29 China 062-38-3360 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 1 ☐ Yes 2 No MD Montgomery Gaithersburg 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20877-United States 407 Russell Ave, Apt. M304 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Bace - American Indian. Black, White, etc 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐Yes 2 ☑ No Specify. Specify: Chinese 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Own Home Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Kalgan Shih Unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Henry Chang/Son 6209 Plainview rd. Bethesda, MD 20817-20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Chesapeake Crematory /0/22/08 Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Rapp Funeral & Cremation Services 21. Signature of Euneral Service Licensee Bruce 1401533 933 Gist Ave. Silver Spring, Maryland 20910-23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Myocardia Immediate Cause (Final Interction disease or condition resulting in death) Due to (or as a consequence of): Hyper Kalemia Sequentially list conditions cause (Disease or injury that initiated events resulting in death) Last Acidosis Metabolic Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 ☑No 1 ☐ Yes 2 ☐ No 1 □ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide

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State Registrar

Alicia Thakor Mistry Inpatient Specialists 9901 Medical Center Dr. Rockville, MD 31. Date filed (Month, Day, Year)

OGT 2 2 20 2008

32. Registrar's Signature

cia J. Mistry

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

OCTOBER 21, 2008

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death OCTOBER 20 **Physician** 2008 Year HENRY COHEN 9:20 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 6810 WILLIAMSON AVENUE BALTIMORE N/A If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 09/29/1928 9. Birthplace (State or Foreign Country)

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\*\*TETATION TO STATE OF THE PROPERTY OF THE 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Min. 216-28-8284 80 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'te Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Director MD N/A BALTIMORE 10g. Citizen of What Country? 10e Street and Number 10f, Zip Code 6810 WILLIAMSON AVENUE 21215 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No WHITE Specify þ 3 Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) OWNER LIQUOR STORE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be NATHAN COHEN SHUGAR 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 33401 BENJAMIN COHEN / BROTHER 470 EXECUTIVE CENTER DR #5K, WEST PALM BEACH, FL 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition 1 A Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) WORKMEN CIRCLE CEM. 10/20/2008 BALTIMORE, MD 22. Name and Address of Facility 21. Signatur of Fureral Service Liespsee SOL LEVINSON & BROS., INC. REISTERSTOWN ROAD - PIKESVILLE, MD 21208 8900 23a. Part 1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** HVEDETTENSIVE /Medical Due to ( as a consequence of) **Examiner** Due to or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician hed for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Ye al 5 Other (specify) 1 ☐ Yes 2 ☐ No signed by the a d be detached f 9 I I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed been s 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident after death 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital or within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kobe TUU Greene 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-07724 State of Maryland / Department of Health and Mental Hygiene 2008 **Donald Durell Dowtin** Certificate of Death 1- For State Rea. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month October 13, 2008 DOWTIN Medical Examiner DURELL DONALD 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Cheverly Prince Georges Hospital Center 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year | If Under 24Hrs. 7. Age (In yrs. last birthday) Social Security Number **Funeral** Months Days Hours 09-19-1966 42 579-82-3750 Director 1 X M 2 Yrs Usual Residence of Decedent 10c. City, Town or Location 10b. County Ę. 28a-f show PRINCE GEORGE'S TEMPLE HILLS with the Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number TISA 20748 4127 CAROZZA COURT 14. Race - American Indian, Black, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status White, etc. or items must be Armed Forces? Never Married 2 Married 2 X No Yes Specify: Yes 2 X No specify: 4 X Divorced If Yes, Give Yea Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Widowed "natural", 16b. Kind of Business/Industry þ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) is marked other than atic event, the Medical HOME DEPOT 21215-0036 MANAGER YRS 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) DOROTHY V. HAWES JAMES D. DOWTIN, JR. Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Pnnt) TEMPLE HILLS, MD 4127 CAROZZA COURT 2 epartment of Health and uportant: If item 27 is jury or other traumat JAMES D. DOWTIN, JR/FATHER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition timore, crematory or other place) Cremation 3 Removal from State X Burial 2 BRENTWOOD, MD 10-20-2008 FT. LINCOLN CEMETERY Other Specify. Department Donation 5 22. Name and Address of Facility MARSHALL'S FUNERAL HOME OF MD 21. Stanature of Funeral Service Licensee 4308 SUITLAND ROAD SUITLAND, MD DONALD R. GRAY r the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician failure. List only one cause on each line Medical a. Multiple Injuries Immediate Cause (Final disease **Laminer** or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last

The law requires that the death certificate be executed Box 68760, Records, P.O. Hospital or Attending Physician: Division of Vital

certificate has been

this

After 1

sician/Medical AMENDED tending physician a UNPENDED 23d. Date of delivery 23c. If yes, outcome of pregnancy 3 Ectopic pregnancy 3b. Was decedent pregnant in the Fetal death past 12 months' Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown ned by the a detached fo 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Yes 2 ✔ No 3 Probably 4 Completed 24a. Was an autopsy performed? ✓ Yes 2 page 2 26.Place of Death (Check only one) 25. Was case referred to medical Be Other<sub>4</sub> Nursing Home 5 Residence 6 examiner? Hospital: 1 Inpatient 2 ✓ ER/Outpatient 3 1 🗸 Yes 28a. Date of Injury 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury 27. Manner of Death Operator motorcycle auto collision Certification: Oct 13, 2008 1730 hrs Yes 2 V No Natural Pending 28f. Location (Street and Number or Rural Route Number, City 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) S/B I -95 South of Central Avenue, Capitol Heights, Md Could not be 3 Suicide determined (Specify) Interstate/Express Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 1 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier October 15, 2008 O.C.M.E.

30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner Donna M. Vincenti, MD

W

2 2 2008

31. Date filed (Month, Day, Year,

111 Penn Street, Baltimore, MD 21201

3. Time of Death

1807 hrs

ITALY

10d. Inside City Limits

1 X Yes 2 No

oreign

Country)

BLACK

20746

Day

death'

1 🗸 Yes

24b. Were autopsy findings available

prior to completion of cause of

Month

Approximate Interval Between Onset and

Death

Year

No

State Registrar

Medical

- IMD

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 17 per fh g884 10-29-08 vt State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** October 11, Marie L. Edler 2008 2358 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Takoma Park Montgomery Washington Adventist Hospital 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗓 F Months Days Hours Director 579-34-4796 81 July 8, 1927 VA Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 X Yes 2 □ No Director Prince George's Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14040 New Acadia Lane 20774 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 2 should be filed within 72 hours after of and Mental Hygiene.

Is marked other than "natural", or ites 1 ☐ Never Married 2 X Married Saltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 🛛 No Specify þ 3 Widowed 4 Divorced Completed other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Printing Specialist Department of Labor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward Bowman Willie Edward Bowman Josephine Craddock 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Item 27 Melvin Edler / Husband 14040 New Acadia Lane Upper Marlboro, MD 20774 permit. Pages 1 a
Department of HeImportant: If Item
any Injury or othe 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland National Cem 10-20-2008 Laurel, MD 22. Name and Address of Facility Marshall's Funeral Home of MD 21. Signature of Euneral Service Licenses t Donald R. Gray 4308 Suitland Road 20746 Suitland, MD 23a. Part1. Fixer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final hevosclerofic **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner the death certificate be executed the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Day Month Year 4☐Pregnant at time of death
9☐Unknown 5 Other (specify) 9 HInknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed? To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 10-13-28 D0060100 10-13-08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AITMED 0 K Universely BLND East Silverspr

State

Registrar

31. Date filed (Month, Day, Year)

2008

32. Registrar's Signature

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			For State	State of Maryland		artment of H rtificate of I		lental Hy		2000	00011
×			Registrar  1. Decedent's Name (First, Middle, La	st)	001	i iiiicale oi i	Dealli	2. Date of De		2000	3. Time of Death
	Physicia /Medic		James Joseph Er	tter				Month Octobe	r 18,	Year 2008	4:30 a M
	Examin	445	4a. Facility Name (If not institution, giv				Location of Death			County of Death	
			Holy Cross Hospi  5. Social Security Number 6. S		act hirthday)	Silver S	Spring If Under 24 Hrs.	8. Date of Bir		lontgome	ry place (State or Foreign
	Funeral Director		216-22-0609	X M 2 F 8(	Van	Months Days	Hours Min.	Dec.11	ay, Year)	Coui	nace (State of Poleigh ntry) DC
	land ow		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Lo	ocation					10d. Inside City Limits
	Mary a-f sh ified	ctor	MD Prince	George Lau	rel						1 ☐ Yes 2L No
	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citize	en of What Cou	ntry?
	s 23a nust t	erai	16005 Kent Road	12. Was Decedent Ever in U.	2 40	20707	ionania Origin? (Cn.	noify Van or Ny	USA	4. Race - Americ	can Indian
0000	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 ★ Married  3 □ Widowed 4 □ Divorced	Armed Forces?  1 Yes, Give  Year or Dates:  12. Was Decedent Ever in O.S.  Armed Forces?  1 Yes, Give	<del>3</del> –	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2☐ No	Specify:	Rican, etc.)		Black, White, Specify.whit	etc.
<u>5</u>	"natura	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)	16a. Dece	dent's Usual Occup kind of work done o DO NOT use retired	ation during most of work	ing	16b. Kind	d of Business/In	dustry
7 7	l within jiene. r than the Me	ошо	Elementary/Secondary (0-12)	College (1-4or 5+)		et Player			U.S.A	rmy Fie	ld Band
and	e filed al Hyg I other vent,	Be C	17. Father's Name (First, Middle, Last	)		-	18. Mother's Name	(First, Middle	, Maiden S	Gurname)	
ylaı	Duld b Ments arked artc e	10	Rudolph Joseph E				Margaret				
Mar	d 2 sh th and 7 Is m traum		19a. Informant's Name/Relationship ( Louella M. Ertte	**		ng Address <i>(Street i</i> 5 Kent Ro					o Code)
a,	tem 2		20a. Method of Disposition			osition (Name of matory or other place		Date		ation - City or To	own, State
allino	Pages ment of ant: If i		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	Jernovai iroin State Davi	clawn	Mem.Park	2008	3		ville,	
Dall	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		21. Signature of Funeral Service Lice	M01053		2. Name and Addres					e, P.A.
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death				-			Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	a Cardiopulmona		rest					Onset and Death
•	/Medical Examiner		resulting in death)	Due to (or as a consequ							
ķ.		Jer	Sequentially list conditions, if any leading to immediate	b. COPD Exacerba							· <del></del>
	ecuted ind transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c							
0/00,	ficate be executed physician and the burial-transit	ial E	resulting in deathy East	Due to (or as a consequ	ience ot):						
00	tificate ig physas the	ledical		0.					- 1		
O. DOX	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of do 9 ☐ Unknown	death 3	⊒Ectopic pregnancy □ Other <i>(specify)</i>	/		23	3d. Date of deliv Month	ery Day Year
ds, T.	signed by d be detac	þ	Part II. Other significant conditions	contributing to death but not resu	ılting in the u	inderlying cause giv	en in Part I.				he cause of death?
ecords,	law req as been 2 shou	Completed						24a. Was		24b. Were auto	opsy findings available ompletion of cause of
<u>.</u>	cate h	Com		-				perf 1□ Yes	ormed?	death? 1 ☐ Yes	2 No
\ \ \	siclan certifi irector	Be	25. Was case referred to medical examiner?  1 ☐ Yes <b>2</b> ( <b>X</b> No	Hospital: 1 ☑ Inpatient 2 □	EB/Outpation	nt 3 DOA Oth	26. Place of Deat			To:: 10	
5	g Phy ter this teral d	n: To	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o	III JU DON	4 □ Nursing Ho	28d. Describe		Other (Speci	fy)
SION	Attending or death. ector: After by the fune	atio	1 Accident 5 Pending 2 Accident investigatio 3 Suicide 6 Could not b	n		M 1 🗆	Yes 2 □ No				
	al or Att	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of injury - At ho building, etc. (Specify	me, farm, sti /)	reet, factory, office		28f. Location ( City or To	(Street and wn, State)	Number or Run	al Route Number,
	e Hospita 24 hours e Funera letely fille	Medical C		nysician: To the best of my knominer: On the basis of examination and manner stated.							
	To th To th comp	Me	29b. Signature and title of certifier	21		29c. Licens				signed (Month,	
			Sink	Them	w	D650			ucto	ber 18,	ZUU8
	10+1		30. Name and address of person who Dr. Sirak Hagos	Lemma, 1500 For	rest G	len Road,	Silver 9	Sprina.	MD 2	0910	
	Sta		31. Date filed (Month, Day, Year)		ture	de)		7 /			
	Registr	ar	001 44 200	0	A A STATE OF THE PARTY OF THE P						

Amend 10e, per FH G884 10/29/08 TT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 19b, perFh G885 11/5/08 TT

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 20 2000 8:06 10 William Edward Freeman /Medical 4c. County of Death 4q. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** Toward F ARK MONTGOMER MASHIGINA HUPIMI Mont If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days 1**Ø**M 2□ F Months Hours Director 524-54-2950 65 11/26/1942 TXUsual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10h. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show Director 1 ☐ Yes 2 🛣 No Silver Spring Montgomery MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Greenacres Funeral 10506 Dr. 20903 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2XNo Specify. þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) US Enviromental n and Mental Hygie Program Manager 18. Mother's Name (First, Middle, Maiden Surname) Be ( 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be Bertha Alyne Bennett ည Eugene Freeman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau Greenacres Freenacres Katherine Freeman/wife 10506 Dr., Silver Spring, MD 20903 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 M Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 10/21/08 Beltsville, MD Chesapeake Crem. 22. Name and Address of Facility Rapp Funeral and Crenation 21. Signature of Funeral Service Licensee 101533 Services, 933 Gist Ave, Silver Spring, MO 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Milmonarn /Medical ue to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a possequence offi-Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Month Year Day 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 Carciomyopas 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy 2 110 1 ☐ Yes 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ∐ Yes 2 100 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 27. Manne Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 atural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Medical 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 10-20-2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1600 Canoll MD AKOMA 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Gibson Ruth Naomi October 0 2008 6:40a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sykesville Carroll Transitions Health Care If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 □ **y**F 217-30-6126 86 **Director** May 12 1922 unknown Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r items 23a or 28a-f show ther must be notified at Funeral Director 1 Yes 2 □ No Carrol1 Sykesville MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21784 USA 7309 Second Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊡Yes 2 ⊡No If Yes, Give X Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Be Completed by 1 □Yes 2 TNo Specify permit. Pages 1 and 2 should be filed within 72 hours a Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturat", o any Injury or other traumatic event, the Medical External Injury or other traumatic event. Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) unknown unknown 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unknown unknown ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 125 Stoner Avenue, Westminster, MD 21157 Gail Jones (guardian) 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2 ☐ Donation 5 ☐ Other (Specify) Sykesville, MD All County Cremation 10-20-08 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service License ▶ Parge Harght & erbert P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** A (zhem /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate causs. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the innerial director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Year Month Day 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 No 3 Probably 4 🖸 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 ☐/No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Datural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Ernesto Mendoza M.D.

31. Date filed (Month, Day, Year)

0050763

826 Washington Rd., Suite 120, Westminster, MD 21157

#### 08-07840 Sharon Lee Grav

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1- For State Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day October 18, 2008 0815 hrs SHARON LEE GRAY Medical Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) N/A 3500 Four Street Apt. #2 9. Birthplace (State or Foreign If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 7. Age (In yrs. last birthday) 6 Sex **Funeral** Country) Maryland 220-78-4180 Months Days Hours June 21, 1958 50 Director 2 X F 1 M Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 X Yes 2 Baltimore N/A Maryland 28a-f shov once. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number or items 23a or 28a-must be notified at 3500 Fourth St., Apt. 2 21225 USA 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 12. Was Decedent Ever in U.S. int Pages 1 and 2 should be filed within 72 hours after death with runent of Health and Mental Hygiene.
Traint: If filen 27 is marked are or other trains 11. Marital Status White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? Never Married 2 X Married 2X No Yes White Yes 2 X No specify: Specify. If Yes, Give Year Widowed Divorced ۾ Dates 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Homemaker Housewife & Mother 0 11 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Betty Jane Snyder Michael Albert Kallay 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) 514 Oakwood Rd., Glen Burnie, Maryland 21061 Shannon Gray (daughter) 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Baltimore, crematory or other place) X Cremation 3 Baltimore, Maryland 10/21/08 Bayview Crematory, Inc. Donation 5 Other Specify permit 2. Name and Address of Facility McCully—Polyniak Funeral Home, P.A. 237 E. Patapsco Ave., Balto., Md. 21. Signature of Fyneral Service Licensee Kevin E Ecker 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line. /Me dittal a. Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical attending physician or use as the burial -UNPENDED AMENDED Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE 23b. Was decedent pregnant in the Day Year 3 Ectopic pregnancy Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 ✓ Unknown a Unknown the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.0. 2 Yes 2 V No 3 Probably 4 Unknown Asthma Completed Records, 24b. Were autopsy findings available peen s 24a. Was an Liver Disease prior to completion of cause of autopsy has performed? death? 2 No Yes 2 V No Yes Schizophrenia certificate 26 Place of Death (Check only one) 25. Was case referred to medical Be Other<sub>4</sub> examiner? Hospital: Residence 6 V Other: Scene DOA Nursing Home 5 Inpatient 2 ER/Outpatient 3 1 Yes No 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of Injury

Hospital or Attending Physician: The law requires that the death certificate be execu Division of Vital this After e Funeral Director: / 24 hours after death.

ို 27. Manner of Death Certification: 1 V Natural 2 3 29a. Certifier Medical

To the OCME State

Registrar

29b. Signature and title o cop pleted cause of death (Item 23a) of pe Deputy Chief Medical Examiner Mary G. Rimble MD.

(Specify)

nd manner stated

32. Registrar's Signature

5

Accident

Suicide

31. Date filed (Month

Homicide

Pending

Investigation

Could not be

determined

Certifying Physician:

2 Medical Examiner: Q

of ce

111 Penn Street, Baltimore, MD 21201

or Town, State)

28f. Location (Street and Number or Rural Route Number, City

October 20, 2008

29d. Date signed (Month, Day, Year)

Yes 2

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

O.C.M.E.

the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

**ORIGINAL** 

28e. Place of Injury - At home, farm, street, factory, office building, etc.

DHMH 17 Rev 1/2001

**OCME 2006** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#9perFH, G885, 11/21/08, WS
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2008 6:45 A M OCTOBER 16, JACK GALE 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death PRINCE GEORGE'S ST. THOMAS MORE HYATTSVILLE If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In vrs. last birthday) Days 1XM 2□F JULY 29, 1914 -PA-SC 94 245-05-9861 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 X Yes 2 □ No WASHINGTON 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20002 USA 1400 FLORIDA AVENUE NE #508 Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Bace - American Indian. Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify: Specify: 3 Widowed 4 Divorced BLACK 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) KOONES DESK CLERK 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) SEEGARS LILLY VANCEY GALE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) EVA P. GALE / WIFE 1400 FLORIDA AVENUE NE #508 WASHINGTON, DC 20002 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 ☐ Cremation 3 □Removal from State 4 □ Donation 5 □ Oth (Specify) Rose Memorial Cemetery 10-26-2008 LANCASTER, SC 21. Signature of Funeral 22. Name and Address of Facility MARSHALL'S FUNERAL HOME OF MD rvice Licensee 20746 SUITLAND, MD DONALD R. GRAY 4308 SUITLAND ROAD ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ire. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the deea shock, or heart fakure rteriorderotic Cardiovascular Piscase Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Disease 1 Tyes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy 2 No 1☐ Yes 26. Place of Death Check onl one Hospital: Other: 4 Aursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No

Examiner requires that the death certificate be executed burial-transit Box 68760, physician the as use for signed by the a P.0. Division or Vital Records, page 2 should I certificate has funeral director, After this death.

**Physician** 

/Medical

Examiner

10a State

6TH

DC

**Funeral** 

Director

r 28a-f show notified at

permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or any injury or other traumatic event, the Medical Examiner must be n

Physician /Medical

Baltimore, Maryland 21215-0036

Director

Funeral

ģ

Completed

Be

Examiner Physician/Medical þ Completed Be 2 Certification:

To the Hospital or Atter of within 24 hours after death To the Funeral Director filled in by

Deunenti 25. Was case referred to medical examiner' 1 Yes 2 No 27. Manner of Death 1 Alatural 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

whony Rd Hyattsville MD 20731 FVORE MD4203QUEE 32. Registrar's Signature 31. Date filed (Month, Day, Year!

State Registrar

one)



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Month A <sup>M</sup> SIDNEY ALLEN GREEN October 18, 2008 11:37 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examine Greater Baltimore Medical Center Towson Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)
APRIL 3, 1 7. Age (In vrs. last birthdav) Birthplace (State or Foreign Country) **Funeral** Months Hours Days 215-86-3508 Director 1975 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show d other than "natural", or items 23a or 28a-f show event, the Medical Eventings is ust be notified at Director XXYes 2 □ No MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2853 EDGECOMB CIRCLE-SOUTH 21215 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐Yes 2☐No Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced Completed 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) nd Mental Hygiene. marked other than COUNSELOR JUVENILE FACILITY 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) ೭ SIDNEY ALLEN GREEN, SR. DENISE C. SMITH 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau S DENISE C. WILKINS/ MOTHER 803 HOPEWOOD ROAD PIKESVILLE, MD 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) METRO CREMATORY 10-21-08 BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. 1701-31 LAURENS ST. BALTIMORE, MD 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) minutes /Medical Due to (or as a consequence of): Examiner subclavian. months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed physician and the burial-tran Due to (or as a consequence of): Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) sate has been signed by the page 2 should be detached 1 ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ₫ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an certificate has autopsy performed? Yes 2 No spital or Attending Physician; The hours after death. Inneral Director: After this certificate by filled in by the funeral director, par 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2√No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1)X Natural 5 ☐ Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral I

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

I Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number **5**00 59873 29b. Signature and title of certifier 1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Laules St. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar ULI 2 2 2008

DHMH 17 Rev 1/2001

Box 68760,

P.O. I

Division of Vital Records.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** October George E. Hamilton 20, 2008 7:10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1706 Wickes Avenue Baltimore N/A 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Funeral Months Days Hours 1X M 2 □ F 215-40-3558 Director 08/19/1942 Baltimore, MD 66 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Experience must be notified at Director 1 ☐ Yes 2 ☐ No MD N/A Baltimore 10e Street and Number 10f Zin Code 10g. Citizen of What Country? 1706 Wickes Avenue Funeral 21230 United States 12. Was Decedent Ever in U.S. Armed Forces? 1X Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Black, White, etc. 1**X** Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. ģ Specify: White 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Chemical Manufacturing permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygis Important: If item 27 is marked other 1 any Injury or other traumatic event, Important or other traumatic event, Important or other traumatic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 George E. Hamilton, Sr. Virginia Lockner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kimberly A. Goswellen (Daughter) 1704 Wickes Avenue, Baltimore, Maryland 21230 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 15 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 DOther (Specify) Loudon Park Cemetery 10/24/2008 Baltimore, Maryland 21. Signature of Funeral Service Licensee Hubbard Funeral Home, Inc. Maut 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the diseas Part1. Enter the disease, and implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final netastatic **Physician** Larungra 1913 disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examiner Due to for as a consequence officause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 ☐Yes 2 ☐ No the 9 Unknown 9 Unknown þ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 2 No 3 Probably 4 Unknown 1 Yes Completed peen 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of has death' certificate 2 🗆 No 1 □ Yes 2 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) examilie: 1 ☐ Yes 2 No Other: 4 \( \sum \) Nursing Home Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 5 Residence 6 ☐ Other (Specify) Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending 2 Accident 1 □Yes 2 □No investigation after death Director; filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide e Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. To the I within 2 To the I 29c. License number 29b. Signatar and title of cert 29d. Date signed (Month, Day, Year) DO057359 ress of person who completed cause of death (Item 23a) (Type, Print) 30. Name and Suite 500 16 ith, Day, Year) 32. Registrar's Signature State 2 Registrar

DHMH 17 Rev 1/2001

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State of Maryland / Department of Health and Me  1 - State   Certificate of Death	Reg. N	0000	00001
			- Neglatia	2. Date of Death		3. Time of Death
	Physicia /Medic		LINDA R. HART	CTOBER 20	0 2008	12:15 P M
	Examin	er	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death		c. County of Death	4/07
	Funeral	-	BALTIMORE WASHINGTON MEDICAL CENTER GLEN BURNIE  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year   If Under 24 Hrs. 8			lace (State or Foreign
	Director		212 00 3371	B. Date of Birth (Month, Day, Yea 07/06/194	9 Balt	imore, MD
	/land low at		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location		1	0d. Inside City Limits
	Mary a-f she ified a	tor	MD Anne Arundel Glen Burnie			1 □Yes 🌠 No
	or 28	Director	10e. Street and Number 10f. Zip Code	10g. C	itizen of What Cour	try?
	eath w		7765 Freetown Road 21060  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Speci		ted State	
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ont, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1	ican, etc.)	Black, White,	
15-0	72 ho "natur	Completed	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b.	Kind of Business/Inc	dustry
212	within iene. than	ошр	Elementary/Secondary (0-12) College (1-4or 5+) N/A Mentally Chal.		N/A	
	be filed a ntal Hygi id other event, th	Be C	17. Father's Name (First, Middle, Last)  18. Mother's Name (i		en Surname)	
Maryland		입		M. Vease		
Mar	D = 12 =	1	19a. Informant's Name/Relationship (Type. Print)  Helen I. Veasel (Aunt/Guardian)  19b. Mailing Address (Street and Number or Rural III)  5025 Montgomery Road, III	-		
re,	es t and 2 of Health fitem 27 i		20a. Method of Disposition		Location - City or To	
imo	Pag nent ant: I		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)  Loudon Park Cemetery 10/24.	/2008 Ba	ltimore,	Maryland
Baltimore,	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service Licensee  Hubl 4107 Wilkens Avenue		ral Home, re, Maryl	
П			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.	respiratory arrest,		Approximate Interval Between Onset and Death
4	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. Due from as a consequence of:	e		
- 1	Examiner		Inumaria			
	St W G	iner	Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  C.	100-00		
	al-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):			
68760,	rificate be executed in physician and as the burial-transit	edical E	d.			
89	ertifica ing ph	Medi	IF FEMALE:			
Box	that the death cert hed by the attendin detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months?	3	23d. Date of deliv Month	ery Day Year
P.O.	the de	Jysic	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Other (specify)			
Vital Records, P	The law requires that the death certificate be executed are has been signed by the attending physician and agge 2 should be detached for use as the burial-transit	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		o use contribute to t	ne cause of death?
ooe	law rec as bee 2 shou	Completed	0	24a. Was an autopsy	24b. Were auto	psy findings available mpletion of cause of
Ä		Com		performed?	death?	
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?  Hospital: 100 April 10			
of	g Physer this eral di	n: <b>T</b> o	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28	e 5 ☐ Residence 8d. Describe how in	6 ☐ Other (Special jury occurred	<u>5y)</u>
ion	Attending r death. ector: After by the funer	atio	1 Matural 5 □ Pending (Month, Day, Year) Injury Work? 2 □ Accident investigation M 1 □ Yes 2 □ No			
Division	I or Att after de Directo	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	Bf. Location (Street City or Town, Sta	and Number or Run ate)	al Route Number,
	To the Hospital or Attending Physician: Within 24 hours after death To the Funeral Director. After this certific completely filled in by the funeral director,	Medical C	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, are considered in the composition of the place of the construction of the place	nd due to the cause d at the time, date a	e(s) and manner as and place, and due t	stated. the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier 29c. License number	29d. [	Date signed (Month,	Day, Year)
	Î		MU D0032744	Oct	st 20	2008
	6		30. Name and address of pelson who completed cause of death (Item 23a) (Type, Print)  301 HOSPITAL DRIVE GIEN BURNIE, MD 21061		,	
	Sta Registr		31. Date filed (Month, Day, Year) OCT 2 2 2008			

HART, LINDA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #10d Per Attorney G885 11/24/08 JH State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** /Medical 4d County of Death City, Town, or Location of Death - Facility Name (If not institution, give street and number) Examiner Kande If Under 1 Year (State or Foreign 8. Date of Birth (Month, Day Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Min. 1X M 2 1 Months Days Hours 81 11/15/1926 MD 216-20-5808 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1**X** Yes <del>2</del>₩o Directo MD BALTIMORE BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21209 USA 2722 HANSON AVENUE Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1∑Yes 2 □ No IfYes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No WHITE Specify: ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than, College (1-4or 5+) Elementary/Secondary (0-12) DEPT. OF DEFENSE PHYSICIST Is marked other 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked othnany injury or other traumatic event once. 17. Father's Name (First, Middle, Last) Be RUTH SACHS HERSTEIN NATHAN ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2722 HANSON AVENUE BALTIMORE, MD 21209 NATALIE HERSTEIN / WIFE 20b. Place of Disposition (Name of MERRO) KODESH BETH ISRAEL 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 10/19/2008 BALTIMORE, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., 21. Signature of Funeral Service Licenses PIKESVILLE, MD 21208 8900 REISTERSTOWN ROAD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Physician/Medical If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part **Jh-Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be rent 205 PICE Other: 4 Nursing Home 5 Residence 6 Other (Specific Certification: To 1 ☐ Yes 2 ☐ Mo 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A neral Director: / 2 Accident investigation 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 29c. License number 30. Name and address of person who completed cause of death item 23a) (Type, Print) 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2008 Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year MILTON, JOHNSON 10 2008 17 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE BALTIMORE CITY GOOD SAMARITAN HOSPITAL If Under 1 Year | If Under 24 Hrs. 6. Sex 1 M 2 □ F 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 69 Months Days Hours 216-34-5939 BlacksTOCK, SC April 18, 1939 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MD Baltimore City 10e. Street and Number 10g. Citizen of What Country? 1700 Meridene Drive ApT 212 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 2 No 1 ☐Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 12 Welder General Motors 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Florence Foster Kobert Johnson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, MD 21239 Shirley Johnson 20a. Method of Disposition 1700 Meridene Dr. Apt 212 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Druid Ridge Oct 28, 2008 Bultimore, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Renall A. Grayson Funeral Service 270 Fred Helton Pass Buttime 21. Signature of Funeral Service Licensee Rurald agrayson MD 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myccardial injurction Due to (or as a consequence of): Atheroscherosis Sequentially list conditions, if any, bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes 2 ☐ No 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes € No

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

10a. State

Director

Funeral

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Completed

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2

**Funeral** 

Director

Show

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be netitled at

Baltimore, Maryland 21215-0036

Examiner The law requires that the death certificate be executed burial-tran Physician/Medical

P.O. Box 68760,

Division of Vital Records,

signed by the attending physician be detached for use as the buria ate has been sign page 2 should be within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, pag To the Hospital or Attending Physician: 1 within 24 hours after death.

Completed

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Certification:

Medical

☐Yes 2☐No 9 Unknown

> Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

27. Manner of Death 1 Matural 5 ☐ Pending investigation 2 Accident 3 Suicide

6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

4 ☐ Homicide

29a. Certifier

29c. License number

29d. Date signed (Month, Day, Year) 10/17/08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NABIL ZEINEH, 5601 LOCH RAVEN BLVD. BALTIMORE, MARYLAND, 21239

State Registrar 31. Date filed (Month, Day, Year)
OCT 2 2 2008



H. 0

State of Maryland / Department of Health and Mental Hygiene 2 11 11 8

		1 - For Registrar  1. Decedent's Name (First, Middle, La:	st)	Ce	rtificate of l	Death	2. Date of De	Reg. No.	2000	3. Time of Dea	
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/Med Exam		4a. Fecility Name (If not institution, giv			4b. City, Town, or	r Location of Deat	h	4c. C	county of Death	1	
		6710 Parkwood St	treet		Landove			Pr	ince Geo	orge's	
Funera Directo		5. Social Security Number 6. S 249–18–8449	7. Age (In yrs. 1918)	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		rth ay, Year) 1916	Cour	lace (State or Foi itry) bia SC	eign
land ow		10a. State 10b. County	10c. City	y, Town or L	ocation	· · · · · · · · · · · · · · · · · · ·			1	0d. Inside City Li	nits
Many	tor	Maryland Prince G	eorge's Lan	dover	Hills					XX 2	]No
th the	lrec	10e. Street and Number			10f. Zip Code			_	en of What Cour	-	
23a	rai	3702 Warner Avenu			2078				d State		
er de Hema	Funeral Directo	11. Marital Status  1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puer	specify Yes or No to Rican, etc.)	0- 1	<ol> <li>Race - Americ Black, White,</li> </ol>		
hours aft	Ď	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:1941		1 ☐ Yes 2X No	Specify:		5	Specify: Bla	ck	
DEIKIMOTE, IMELYIEING ZIZIS-UUSO permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Depertment of Heetth and Mentei Hygiene. important: If item 27 is marked other then "naturel", or items 23s or 28s-f show eny injury or other traumatic event, the Madical Examinar must be notified at	Completed	15. Decedent's E (Specify only highest gra	ducation	16a. Dece	dent's Usual Occup	ation during most of wo	rkina		d of Business/In		
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iled wi Hygien Hher th	S	Twelth  17. Father's Name (First, Middle, Last)	None	Pri	iter	18 Mother's Na	me (First, Middle			LTTHCTHE	,OI
ytand buld be fill Mentei Hi arked oth	Be	George Jackson	,				e Sultar		2771411107		
should be and Mentei Is marked o	To	19a. Informant's Name/Relationship (	Type, Print)	19b. Mail	ing Address (Street	and Number or R	urai Route Numi	er, City or	Town, State, Zip	Code)	
and 2 st and 2 st setth and n 27 is n		Michael Jackson/S	on	3702	Warner A	Ave., La	ndover H	lills	MD 2078	4	
or He or He		20a. Method of Disposition  1 XBurial 2 Cremation 3	Removal from State	lace of Disp emetery, cre	osition (Name of matory or other place	Octo	Date ober 18	20c. Loc	ation - City or To	own, State	
Pag ment ant: #		4 Donation 5 Other (Special		k Cree	k Cemeter			Wash	ington	DC	
Baltimor permit. Pages Depertment of Important: if it important: if it	i	21. Signature of Funeral Service Lice		2	2. Name and Addre	ss of Facility	Frazier'				
4 40200	1	Wy Geffers	polications that caused the death	·	389 Rhode				h DC 20	001 Approximate	
	•	23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	$\boldsymbol{\nu}$	. /			c or respiratory	arrest,		Interval Between Onset and Deat	h h
Physiciar /Medica		disease or condition resulting in death)	a. Due to (or as a conseq		Canc.	er					
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n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a conseq	uence of):							
ecuter and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C								
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rificate be executed ng physicien and as the burial-transit	Medical	***	d								
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death ce	sicia	in the past 12 months?	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown		□Ectopic pregnancy □ Other (specify) _	у			Month	Day Year	
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ecords, P. iaw requires that as been signed b	ģ	Part II. Other significant conditions	Decubitors	witing in the	underlying cause giv	ven in Part I.			No 3∐Prol	he cause of deati	
w require been significations	Completed	1/-/		- 10							
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VISION Attending r death. ector: After	atic	Natural 5 Pending 2 Accident investigation	on		M 1 🗆	Yes 2 □No					
S g g z	Certification:	3 Suicide 6 Could not to determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, s fy)	treet, factory, office			(Street and own, State)		al Route Number	
To the Hospital within 24 hours each to the Funerel I completely filled	Medical	(Check only 2 Medical Exa	hysician: To the best of my kno miner: On the basis of examina and manner stated.	owledge, dea ation and/or i	nvestigation, in my o	opinion, death occ	e, and due to the curred at the time	e, date and	place, and due	to the cause(s)	
To the within 2 To the complet	Σ	29b. Signature and title of certifier	16		29c. Licens				e signed (Month,		
1	1	Many	Her			323	5	101	15/08		
5		30. Name and address of person who	completed cause of death (Iter	n 23a) (Type	Print)	1hon	2 K	he	lan	elp	10
	State	31. Date filed (Month, Day, Year)	32. Begistrar's Signa		1=-	11000	, , (				
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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#1perPHYS G884 10/31/08 WS.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last Edward Lewis Jordan 3. Time of Death 2. Date of Death Month Day 18 **Physician** 2:40 PM Edward 08 Jordan /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner University of Maryland Hospital If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Min. Months Days Hours 1 M 2 □ F Director 50 07/14/1958 214-72-6753 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State ? Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Director MD Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? within 72 hours after death with 3120 Texas Ave 21234 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify. δ Specify. 3 Widowed 4 M Divorced 1975-1977 White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important; if item 27 is marked other than any injury or other traumatic event Construction Elementary/Secondary (0-12) College (1-4or 5+) Laborer 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Edward Lewis Jordan Christine Reedy 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christine Jordan/Mother 3120 Texas Ave. Parkville, MD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 🛛 Cremation 3 ☐ Removal from State Oct 22 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, Maryland Chesapeake Crematory Inc. 2008 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, Maryland 21286 23a. Part 1. Einter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Two days Intraventricular hemorrhage /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to or as a consequence of The law requires that the death certificate be executed and trar Due to (or as a consequence of) physician a s the burial. Box 68760, Physician/Medical attending p IF FEMALE: . If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) ed by the detached f P.0. 9 Unknown 9 Unknown signed I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown has been si e 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed page certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 Mo 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To 27. Manner of Death 1 ■ Natural 28b. Time of 28a. Date of Injury 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day Year) Injury 5 Pending investigation To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fun 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 □ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Rawal, M.D. 18872 October 19,2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) University of Maryland Department of Neurosurgery 22 S. Greene Street BYAN NOWAK 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Suite &-12-P 22 2008 Baltimore, mp 21201 Registrar

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month / KENNED 2008 TANET 4c. County of Death Frederick 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number Adamstown BUCKINGHAM CHOICE HEACH CARE If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 5. Social Security Number Days 1 □ M 2 1 F 93 085-26-4407 Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10b. County 1 ☐Yes 2 No Adamstown MD. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 3200 Baken Circle U5 A 21710 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc 1 Never Married 2 Married Specify: WHITE 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) NEW YORK College (1-4or 5+) Elementary/Secondary (0-12) UNIVERSITY REGISTRAR FOR UNIVERSITY Yrs. 18. Mother's Name (First, Midele, Maiden Surname) 17. Father's Name (First, Middle, Last) Clemmie Charles F. Kenned 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Canby Rd Va 20175 Corderman (nicce) 17542 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition Smiths buy hid Oct 17,2008 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Smiths burg Evernatory 4 □ Donation 5 □ Other (Specify) 21. Signat / of Furreral Service / ensee 2. ame and Address of Facility 7.2 L. Jollins Frant ONE ST. FREDERICK, MO. 2110/ Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Day 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Munknown 24a, Was an

**Physician** /Medical Examiner

Physician

/Medical

Examiner

10a. State

Director

Funeral

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Completed

Be

Funeral

Director

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

'natural", or items 23a or

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permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygic Important: If item 27 is marked other i any injury or other traumatic event, ti

must be

and P.O. Box 68760, attending physician for use as the burial the signed by þe

Vital

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Division Hospital or Attending

the

page 2 should certificate funeral director. this After t within 24 hours after death.

To the Funeral Director: A
completely filled in by the fu

Physician/Medical þ

Be Completed Certification: To

Examiner

IF FEMALE: 9 I Inknown

1 ☐ Yes

27. Manner of Death

1 M Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 PNo

W ase referred to medical examiner?

2 No

Albume, a

5 ☐ Pending investigation

6 Could not be determined

performed?

24b. Were autopsy findings available prior to completion of cause of death?

2 No Yes 26. Place of Death (Check onli one

2 No 1 ☐ Yes

Other: 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred

28c. Injury at Work? 28b. Time of (Month, Day Year) Injury 1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 🔲 Inpatient

28a. Date of Injury

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and magner stated.

29d. Date signed (Month, Day, Year)

32. Registrar's Signatu

State Registrar

Medical

10

		-	For State of M State Registrar	aryland / Depa <i>Cer</i>	artment of H r <i>tificate of E</i>			ene 008	33627	
	Dharaint		1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death	
	Physicia /Medic		Doris H. Kahrs		r		October	20, 2008	3:15 P <sup>M</sup>	
SK. A.	Examin		4a. Facility Name (If not institution, give street and number,		4b. City, Town, or			4c. County of Death		
e i			337 Greenlow Road	- (In the local birth dots)	Catons If Under 1 Year		8 Date of Birth	Baltimo		
	Funeral Director		1□M 21XF	ge (In yrs. last birthday) 82 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, July 2,		thplace (State or Foreign ountry) ryland	
	p. ,		Usual Residence of Decedent  10a State 10b County	10c. City, Town or Loc	cation				10d. Inside City Limits	
	aryla Shov	7	,	Catonsvi					1 □ Yes 2 ⊠ No	
	he M	Director	Maryland Baltimore  10e. Street and Number	Catonsvi	10f. Zip Code		110	og, Citizen of What C	ountry?	
	a or		337 Greenlow Road		2122	9.8		USA		
•	be filed within 72 hours after death with the Maryland Hygiene.  d other than "natural", or items 23a or 28a-f show event, the Medical Everniner mast be motified at	Funeral	11. Marital Status  12. Was Decedent Armed Forces  1  Never Married 2  Married 1  Yes 2	No	Was Decedent of Hi If Yes, specify Cuba 1 □ Yes 2 🗓 No		ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whit Specify: Wh:	te, etc.	
200-0	ours a	d by	3 X Widowed 4 □ Divorced If Yes, Give Year or Dates:							
	72 h	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usual Occupa kind of work done d DO NOT use retired,	ation <i>Juring m</i> ost of worki	ng ^	16b. Kind of Business	_	
7	filed within Hygiene. other than '	du	Elementary/Secondary (0-12) College (1-4or 1 2	5+)	retary	,		ingineers	OI.	
7	e filed v al Hygie other i	ပို	17. Father's Name (First, Middle, Last)	beer	ceary	18. Mother's Name				
Mai yiaila	should be I and Mental s marked o tumatic eve	o Be	Moses Hudson			Rose Bow	ersox			
<u></u>	2 should be and Menta is marked aumatic ev	은	19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	ng Address (Street a	and Number or Run	al Route Number	City or Town, State,	Zip Code)	
	and 2 s ealth al n 27 is ner trau		Susan Lewis Daught	er 2862	Thornbroo	k Road;	Ellicott	City, Ma	ryland 21042	
ע	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any Injury or other traumatic evonce.		20a. Method of Disposition  1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Dispo cemetery, cren Atlantic	osition (Name of matory or other place Crematory	10/22	/2008 G	20c. Location - City of	rTown, State e, Maryland	
Dall	permit. Popartm Departm Importar any Injur		21. Signature of Funeral Service Licensee	10/490 1 E	2. Name and Addres Funeral Ho	ome of Ca	rling Ás tonsvill pue: Cat	hton Schwa e, Inc. onsville,	ab Witzke MD 21228	
Ħ			23a. Part 1. Enter the disease, or complications that cause	d the death. Do not ent	ter the mode of dyin	g, such as cardiac	or respiratory arr	est,	Approximate Interval Between	
	Physician /Medical		shock, or heart failure. List only one cause on each Immediate Cause (Final disease or condition resulting in death)  Due to (or a		Onset and Death					
	Examiner		Sequentially list conditions b.							
-	p ii	Examiner	Sequentially list conditions, if any, leading to miniodate cause. Enter Underlying Cause (Disease or injury	s a consequence of):						
	icate be executed physician and the burial-transit	хаш	that initiated events c.	s a consequence of):			<del>.</del>			
Š	be ey ician burial	置	Due to (or a	s a consequence on.						
00/00	physicate the l	edical	d							
C. BOX 0	the Hospital or Attending Physician: The law requires that the death certificate be executed bin 24 hours after death. The law seems igned by the attending physician and the Funeral Director: After this certificate has been signed by the attending physician and mipletely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 No 9 □ Unknown  23c. If yes, outcom 1 □ Live birth 4 □ Pregnant 9 □ Unknown	23d. Date of d Month	elivery Day Year					
as, F.	uires that the signed by Id be detac	þ	Part II. Other significant conditions contributing to death	but not resulting in the u	underlying cause give	en in Part I.	23e. Did tol	<u>-</u> .	to the cause of death?  Probably 4 Unknown	
Records,	: The law requir icate has been s , page 2 should	Completed					24a. Was a autops perform	ned?   death'	autopsy findings available or completion of cause of caus	
<u>a</u>	sician: Th certificate rector, pag	Be C	25. Was case referred to medical			26. Place of Deat				
>	nysician: nis certific director, I		examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpa	tient 2 ER/Outpatie	ent 3 □ DOA Oth	er: 4 \sum Nursing He	ome 5 Resid	ence 6 □Other (Sp	pecify)	
פחכ	ding Phys th. After this funeral dir	L:uoi	27. Manner of Death  1 Natural 5 Pending (Month, L		Wor	yat <br Yes 2 □ No	28d. Describe he	ow injury occurred		
DIVISION OF VITAL	To the Hospital or Attendin within 24 hours after death.  To the Funeral Director: Aft completely filled in by the fur	Certification: To	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of I building,	njury - At home, farm, st etc. <i>(Specify)</i>		100 = 25.10	28f. Location (S City or Tow	treet and Number or in, State)	Rural Route Number,	
_	B Hospita 24 hours Funeral etely fillec	Medical Co	29a. Certifier (Check only one) Certifying Physician: To the beside and manner and manner	of examination and/or it	ith occurred at the ti nvestigation, in my o	me, date and place ppinion, death occu	, and due to the or rred at the time, o	cause(s) and manner late and place, and d	as stated. ue to the cause(s)	
	To the within To the Somple	Me	29b. Signature and title of certifier	105	29c. Licens			29d. Date signed (Mo		
	~		burs framely		I	1858	+ 1	OCT 21	2008	
7	10		30. Name and address of person who completed cause of	ov Cat	Fon Av	e Be	e (time	ve MD	21229	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) 32. Regit	strar's Signature	Sarah					

			for State	State	f Marylar	-	artment of I		nd Menta	Hygien	e	00600
	-		Registrar  1. Decedent's Name (First, Middle	o (act)		Ce	rtificate of	Death	2 Date	Reg. N	0.2008	33621
- 2	Physici	an		e, Lasi)		77			Mon	th D	ay Year	Time of Death     M
4	/Medic Examir		Patricia  4a. Facility Name (If not institutio.	n, give street and nu	mber)	Kend	4b. City, Town, o	or Location of			20, 2008 c. County of Death	1 7:20 A
	LXaiiiii	5	Marley Neck He	alth and	Rehab.		Glen	Burnie	9		Anne Aru	ınde1
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 ☐ F	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24	4 Hrs. 8. Date	of Birth oth, Day, Yea		lace (State or Foreign
ü	Director		215-30-3691 Usual Residence of Decedent	ILIM PEI	73	Yrs.			Jul	y 18,1	935   Mary	land
	/land ow at		10a. State 10b. County		10c. Cit	ty, Town or Lo	ocation				1	0d. Inside City Limits
	a-f sh	tor	Maryland Ann	e Arundel	G1	en Bur	nie					1 ☐ Yes 2 ☐ No
	or 28	Dire	10e. Street and Number				10f. Zip Code			10g. C	itizen of What Cour	itry?
	ath w	ral	925 Blakistone			- T		1060			U.S.A.	
	item item	Funeral Director	<ul><li>11. Marital Status</li><li>1 ☐ Never Married 2 ☐ Mar</li></ul>	Armed F		.S.   13.	Was Decedent of I If Yes, specify Cub	Hispanic Origi pan, Mexican,	in? (Specify Yes Puerto Rican, e	tc.)	14. Race - Americ Black, White,	
920	urs af al", or Exam	þ	3 Widowed 4 □ Divorced	If Vac G	ve		1 ☐ Yes 2 🕅 No	Specify:			Specify: Whi	te
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notified at	Completed	15. Deceder	t's Education st grade completed)		16a. Dece	dent's Usual Occu	pation	of working	16b.	Kind of Business/Ind	
21	/ithin ne. han "	mple	Elementary/Secondary (0-12)	College (	1-4or 5+)		kind of work done DO NOT use retire	,	g			
	Hygie Hygie Ther t	S	11 17. Father's Name (First, Middle,	N/A			lomemaker		's Name (First, I	Middle Maide	Own Home	
an	Mental arked o	To Be	Henry			7. obi.		The1m	•	, , , , , , , , , , ,	,	17 11.
Maryland	and Men is marke	F	19a. Informant's Name/Relations	hip (Type. Print)		Zephii 19b. Maili				Number, City	or Town, State, Zip	Kelly Code)
	and 2 ealth a n 27 is		Joann K. Frame	(Daughter	)	925	Blakistor	ne Road	l_G1en B	urnie.	Maryland	21060
ore	jes 1 of He If Iten or oth		20a. Method of Disposition 1 X Burial 2 ☐ Cremation	3 □Removal from		Place of Dispo cemetery, cre	osition (Name of matory or other pla	ace)	Date	20c.	Location - City or To	wn, State
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		4 □ Donation 5 □ Other (5	Specify)			Cemetery		0/25/08	Ba1	timore, M	aryland
Bal	permit. Departr Importa any Inji		21. Signature of Funeral Service	Licensee			2. Name and Addre			1 Home	P.A.	
	-	_	23a. Part1, Enter the disease, o	complications that	caused the deat	th. Do not en	204 Mount ter the mode of dy	ain Ro	ad Pasa ardiac or respira	dena,	Maryland	21122 Approximate
	Physician		shock, or heart failure. List Immediate Cause (Final	only one cause on	each line.	8.	a = 1	и				Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to	(or as a conseq	quence of):	y men	Port				
	Examiner		Sequentially list conditions	b		Sei	Zures					
	B V 5	Examiner	Sequentially list conditions, if any, leading to in modulate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a nonsac	niesee of):						
	xecut	хап	that initiated events resulting in death) Last	c	(or as a conseq	uence of):						
,092	ificate be executed g physician and as the burial-transit	calE		d.								
68	rtificat ng phy as th		15.55141.5									
Вох	The law requires that the death certifica are has been signed by the attending phage 2 should be detached for use as the	Physician/Med	IF FEMALE; 23b. Was decedent pregnant in the past 12 months?		tcome pf pregna		∃Ectopic pregnand	cy .			23d. Date of delive	*
Ö.	ne dea the at hed fo	/sici	1 ☐ Yes 2 Ø No 9 ☐ Unknown	4□Preg 9□Unkr	nant at time of o		Other (specify)				Month	Day Year
P.O.	that the ed by detac	Ph)	Part II. Other significant conditi	ons contributing to d	eath but not res	ulting in the u	nderlying cause gi	ven in Part I.	23e	. Did tobacco	use contribute to the	ne cause of death?
Division or Vital Records,	w requires that been signed b should be deta	d by		_			, , ,		- ()	1 🗆 Yes	2 No 3 Prob	ably 4 Unknown
000	sw rec	Completed						<u> </u>	24a	. Was an	24b. Were auto	psy findings available
Be	sician: The law certificate has t irector, page 2 s	mo							_	autopsy performed? Yes 2 101	death?	npletion of cause of 2 <b>⊠</b> No
ita	ctor, p	Be C	25. Was case referred to medica examiner?	1				26. Place o	of Death (Check		12,00	
<u>7</u>	Physic this ce al dire	မ	1 ☐ Yes 2 No		Inpatient 2	· · · · · · · · · · · · · · · · · · ·	IL 3 DOA		1		6 □Other (Specif	v)
N N	ding P	ion:	27. Manner of Death 1 ☑ Natural 5 ☐ Pendir	y ·	of Injury hth, Day Year)	28b. Time o Injury	Wo	rk?		cribe how inj	ury occurred	
isi	Attend death ctor; y the	licat	2 Accident investi 3 Suicide 6 Could	not be 280 Place	of injury - At he	ome, farm, st	M 1 =	]Yes 2□N		ation (Street a	and Number or Rura	I Route Number
<u>S</u>	al or / s after il Dire	Certification:	4 ☐ Homicide determ	build	ing, etc. (Specia	fy)	,		City	or Town, Sta	te)	
	To the Hospital or Attending Physician: The within 24 Hours after death.  To the Funeral Director: After this certificate h. completely filled in by the funeral director, page		29a. Certifier 1 Certifyli (Check only 2 Medical	ng Physician: To the Examiner: On the b	e best of my kno	owledge, deal	h occurred at the t	ime, date and	place, and due	to the cause	s) and manner as s	tated.
	To the H within 24 To the F complete	Medical	one)	and mar	iner stated.							
	Viiti	2	29b. Signature and title of certified	hougher			29c. Licens	se number	2 1	29d. D	ate signed (Month,	Day, Year)
	1,	}	,,,,	who completed and	en of death /!	n 22a\ /T	Print) 23-	4-11	7 Am >	2 0	Comment	2-6
	Ч		30. Name and address of person DR OCHANE	who completed caus	se oi death (iter	ıı∠əa) (Type,	50	EN I	BURNIE	THUE A	ate signed (Month, tober 21 Suite 21061	08
	Sta	te	31. Date filed (Month, Day, Year)	32. F	Registrar's Signa	ature	3			11.1		
	Registr	ar	OCT 2 2	2008	year A	403	W)					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month 06:30 AM **Physician** Robert A-Kemp 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A If Under 1 Year If Under 24 Hrs. tarbor Itosp Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days Hours Min 1**1** M 2□ F 218-58-7329 55 Jan 12. 1953 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 7 is marked other than "natural", or items 23a or 28a-f shot traumatic event, the Modert Examiner must be redflied at 28a-f shov 1 ¥ Yes 2 □ No Baltimore N/A Director Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21230 USA 2805 Eastshire Drive 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 2 should be filed within 72 hours after on and Mental Hygiene.

Is marked other than "natural", or iter 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: þ White 3 Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Disabled N/A 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Juanita Frances Quick Matthew Adolphus Kemp 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health a Important; if item 27 is any injury or other trau once. 6829 Woodcrest Rd., New Market, Md. Richard D. Kemp (Brother) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Rosedale, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith Cemi 10/24/08 22. Name and Address of Facility
McCully-Polyniak Funeral Home, P.A. 21. Signature of Finera Syvice Licensee Kevin Ε Ecker 237 E. Patapsco Ave. Balto., Md. shock, or heart failure. List only one cause on each line. 21225-1856 Approximate Interval Between Onset and Death Immediate Cause (Final Larly **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner epatitis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner The law requires that the death certificate be executed the burial-transit physician and Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 🕱 No 5 ☐ Other (specify) 9 Unknown been signed be should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an endo cardeti certificate has birector, page 2 st autopsy performed? Yes 2 No 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28b. Time of Injury 27. Manner of Death Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending s after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident the Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours a

To the Funeral I

completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 10/20/08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 300 500 am, Itanous

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

Year)

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 13 ice 10 2008 MOYM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner (Y ensing lontgomer Hrden 8. Date of Birth (Month, Day, Security Number 7. Age (In yrs. last birthday) Year) 1934 **Funeral** Days Min Months Hours 1 □ M 2 🕏 F Yrs. 84 Director 085-26-4611 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, fire Medical Examinations to confine an once. 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 Dres 2 □ No Director Kensina Mon 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20895 USA 4301 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 12. Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 🗖 No Specify: Be Completed by Whit 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) FIGER ဂ္ Rubinstein 19b. Mailing Address (Street and Number or Rural Route Number, wy or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State letro 4 □ Donation 5 □ Other (Specify) xematorui 18434 22. Name and Address of Facility 21. Signature of run ral Service Licensee Approximate Interval Between Valle 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, ownear failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

District (Case as assessment of the condition of the conditi Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the buriaf-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the nast 12 months? 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Year in the past 12 mort Pregnant at time of death 5 ☐ Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐Yes 2 ☐ No 1 ☐Yes 2 ☐No 25. Was case referred to predical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Howice 1∐ Yes 2 **D**NO 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this funeral 27. Man of Death 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of 5 Pending investigation 1 ☐Yes 2 ☐ No ours after death. Ieral Director: A filled in by the fu death. 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 3 30. Name and address of person who completed ause of death (Item 23a) (Type, Print) 8218 KAUFR

State

Registrar

31. Date filed (Month, Day, Year)

2 2 2008

32. Registrar's Signature

08-07780 Margot Kjer Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2008 3363

		- For State	Certi	ificate of	Death			Reg. No.	
Physicia		egistrar 1. Decedent's Name (First, Middle,L	ast)			7.0	2. Date of Month	Day Ye	3. Time of Death
edical Examin			Margot Kjer			`		er 15, 2008	
	Í	4a. Facility Name (if not institution, 302 E. Joppa Road #30			b. City, Town, or Towson	Location of D			ore County
Funeral		5. Social Security Number 6.	Sex 7. Age (In yrs. las	t birthday)	If Under 1 Yea	_		f Birth (MM/DD/YYY	9. Birthplace (State or Foreign Country)
Director			_м 2, к 82	Yrs	Months Day	s Hours	Min. 08/	23/1926	Germany
any		Usual Residence of Decedent  10a. State 10b. County	10c. City, T	own or Locati	on				10d. Inside City Limits
<b>*</b> .	_ 1	MD Balti	more To	wson					1 Yes 2 No
Maryland r 28a-f show	양	10e. Street and Number			10f. Zip Code			10g. Citizen of V	Vhat Country?
a or	Director	302 E. Joppa	Rd. Apt. 309		21286	5		USA	
	era	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?		s Decedent of His es, specify Cubar				ce - American Indian, Black, ite, etc.
deatl	Fu	1 Never Married 2 Marr	1 Yes 2 No			specify:		Specify	White
s afte	ᇗ	Widowed 4 Divor	or Dates:		t's Usual Occupa		d of work done		Business/Industry
2 hour	eted	Elementary/Secondary (0-12)	College (1-4 or 5+)		ost of working life		e retired)	Impor	t/Export
21215-0036 Juid be filed within 72 Mental Hygiene, marked other than 'e event, the Medical	omple	12		Self-	Employe				
5-0036 led within 7 Hygiene. I other than	υl	17. Father's Name (First, Middle, L	ast)				Name (First, Mic	ldle, Maiden Surnan	·
121 d be fi lental arked	B	Unk Unk  19a, Informant's Name/Relationshi	/Tune Brint	19h Mailin	n Address (Stre	Unk	r or Rural Route	e Number, City or To	Oeder own, State, Zip Code)
nore, MD 21215-0036 sges 1 and 2 should be filed within 72 hours after nt of Health and Mental Hygique. t: If item 27 is marked other than "natural", other traumatic event, the Medical Examiner.	2	Paul Dziwanow	ski/Friend			Land I	r. G1	en Burni	e. MD 21060
ore, M ss 1 and 2 of Health If item 2 her traur	•	20a. Method of Disposition		lace of Dispos	sition (Name of ce	emetery,	)c.t Date 1	20c. Location	n - City or Town, State
Baltimore, MD 21215-00; permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other thinjury or other traumatic event, the Med		1 Burial 2 Cremation	Ch	rematory or ot	ake Cre	em.	2008	''Belts	n - City or Town, State
Baltimc permit. Page Department Important: Injury or ot		21 Signature of Funeral Service L	City.			s of FaciliO	FA/Ste	ephen D.	Lohrmann P.A.
E P P E		Ly la dre	KAR	_	8 <b>717</b> G1	een F	astur	es Dr. B	Balt.MD, 21286
Physician		23a. Part I. Enter the disease, or c failure. List only one cause o	omplications that caused the death. n each line.	Do not enter	the mode of dying	, such as card	ac or respirato	ry arrest, snock, or i	Between Onset and Death
'M dical	3	Immediate Cause (Final disease or condition resulting in death)	a Matastatic ca		a				Death
		24	Due to (or as a consequence of b.	).					
	Jer	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of	):					
_	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of	):					
executed an and al - transit		events resulting in death) Last	d						
- 00 '57'5	edical	X UNPENDED	X AMENDED 23a,27,	per M ME g88	E g884 1 <b>35 11.12</b>	1/5/08 <b>.08 TT</b>	TT		
760, Treate be g physicis the buria	/Me	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pregr	nancy	etal death 3			23d. Date Month	e of delivery n Day Year
Sox 687 leath certifing e attending for use as t	ian	past 12 months?	1 Live birth Pregnant at time of de	- 44	etal death 3	Ectobic	ледпапсу	Mont	. Day
Box e death of the atten	Physician	1 Yes 2 V No 9 Unkr	9 OHKHOWH						
b.O. Be that the de		Part II. Other significant condition	ons contributing to death but not re	esulting in the	underlying cause	given in Part			ontribute to the cause of death?  3 Probably 4 Unknown
ires that the signed by do be detached	ed by						_		b. Were autopsy findings available
w requires been should	Completed							autopsy performed?	prior to completion of cause of death?
Reco	Eo						1 🗸	Yes 2 No	1 ✓ Yes 2 No
Vital Recysician: The his certificate director, page	Be C	25. Was case referred to medical examiner?	Hospital			Tour	Check only one)	e	C A Other Come
of Vital Records, g Physician: The law requir Note this certificate has been some and a continued to the continued of the control of the cont	ToE	1 ✓ Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatier 28b. Time of		jury at Work?	Nursing Home	5 Residence	6 Other: Scene
n of \ding Phy		27. Manner of Death  1 X Natural 5 Pendi	28a. Date of Injury (Month, Day, Year)	200. Time of		Yes 2		,,	
Sion Attend r death ector: by the	cati	2 Accident Inves	tigation 28e. Place of Injury - At h	ome, farm, str	eet, factory, office	building, etc.			imber or Rural Route Number, City
Division pital or Attendio ours after death. reral Director: /	Certification:	3 Suicide 6 Could determ	not be				or T	own, State)	
Hospi 24 hou Funer rtely fil		29a. Certifier	ysician: To the best of my knowled	ge, death occ	urred at the time,	date and plac	e, and due to the	ne cause(s) and mar	nner as stated.
To the within To the comple	Medical		niner: On the basis of examination a and manner stated.	ind/or investig					signed (Month, Day, Year)
	Σ	29b. Signature and title of certifie				nse number C.M.E.			16, 2008
		Unel 2		. 00-1				30.030	
10xy.			who completed cause of death (Item istant Medical Examiner	123a) 111 Penn	Street, Baltir	nore, MD 2	21201		
	tate	31. Date filed (Month, Day, Year)							
Regis		I 0 0 00	08 Degree At	San San San San San San San San San San	Barrier .				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Physician /Medical of Death 4a. Facility Name (If not institution, give street and Examiner Landallstow More If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 03/16/1908 Social Security Number 7. Age (In vrs. last birthday, **Funeral** Days 1 □ M 2 X F 216-24-5773 100Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Modical Expanient must be notified at 1 □Yes 2X No Director BALTIMORE BALTIMORE MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2 should be filed within 72 hours after death with and Mental Hygiene. Is marked other than "natural", or items 23a or 21208 USA 8 POMONA WEST, Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 WHITE 1 □Yes 2 X No Specify Specify: δ 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) OWN HOME HOMEMAKER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be SARAH UNKNOWN SAMUEL SCHMALL ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) mit. Pages 1 and 2 s partment of Health an portant: If item 27 Is 1 Injury or other trau POMONA WEST, #12, BALTIMORE, MD 21208 FRANCES CHESSER / DAUGHTER Baltimore, 20b. Place of Disposition (Name of cometery, crematory or other place)

MEMORIAL PARK 20c. Location - City or Town, State Date 20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any Injury or once. 10/19/2008 RANDALLSTOWN, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licenses SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence 3): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): be executed and burial-trar Due to (or as a consequence of): attending physician for use as the buria Box 68760 Physician/Medical The law requires that the death certificate 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No
9 □ Unknown 23d. Date of delivery 3 - Ectopic pregnancy signed by the atte Month Day Year 5 ☐ Other (specify) P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 4 Unknown 1 Yes 2 No 3 Probably Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 2 No 1 ☐ Yes After this certifica funeral director, p or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) nen Hospital: Other: 4 Nursing Home 5 Residence 200 No 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 6 Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural 2 Accident 5 Pending investigation n 24 hours a er death.

ne Funeral Director A
nletely filled in by the fi death. 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide Hospital completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated To the within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certific

State Registrar 30. Name

Day, Year) 31. Date filed (Month) 2 2 OCT

2008

son who completed cause of death (It in 23a) (Type, Print) 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year LAM BACK **Physician** 2008 23:20 P OCTUBER KUBERT /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner **Baltimore City** The Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Hours **Funeral** 1 X M 2 □ F 64 Dec 22. Director 212-44**-**6570 Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygiene.

m 27 Is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ä 1

Yes 2 □ No MD Baltimore Director must be notified 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number 1535 Patterson Park Avenue 21213 USA Funeral Unk 12. Was Decedent Ever in U.\$\text{\mathbf{n}}\text{\mathbf{k}}\text{\text{Armed Forces?}}\text{\text{arried}}\tag{1 \subseteq \text{Yes} \ 2 \subseteq \text{No}\text{\text{l}}\text{ 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11 Marital Status the Medical Examiner 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: black <u>م</u> 3 Widowed 4 Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unl unk 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) unk 18. Mother's Name (First, Middle, Maiden Surname) unk 17. Father's Name (First, Middle, Last) Be ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 Is any injury or other tra The Johns Hopkins Hospital 600 N. Wolfe Street Baltimore. MD 21287 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) In State state Anatomy Board 655 W. Baltimore Street 21. Signature of Funeral Service e Licensee S. Wade Baltimore, MD 21201 28a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) METABOLIC **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner One to for self-during of, MEGACOLO burial-transit OXIC and Due to (or as a consequence of) attending physician Box 68760 Physician/Medical The law requires that the death certificate be as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Tectopic pregnancy Month Day detached for in the past 12 months? 5 Other (specify) 2 🗌 No P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Division of Vital Records, 3 No 1 Tes 3 Probably 4 Unknown Atter this certificate has been siç funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗌 No 8/ 25. Was case referred to medical examiner? 26. Place of Death (Check only one Be Other: 4 Nursing Home 5 Residence Hospital: 2 ER/Outpatient 3 DOA 6 Other (Specify) 2 HO Inpatient 1 🗌 Yes ၉ 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 28c. Injury at Work? Certification: 1 Natural 2 Accident 5 Pending investigation or Attending 1 Yes 2 No s after death. by the f 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, 4 - Homicide City or Town, State) Hospital 24 hours Entifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number . 29b. Signature and title of certifles 2008 RES - 000 OCTOBER

DHMH 17 Rev 1/2001

State

Registrar

don't

600 North Wolfe St, Baltimore, MD, 21287

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

32 Registrar's Signature

PARAM.

RAVI KANT 31. Date filed (Month, Day, Year)

OCT 22

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 3. Time of Death Date of Death Month 1. Decedent's Name (First, Middle, Last) Mitchell 2:30a Cyri1 2008 **Physician** October Ernest /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Prince George Laurel Laurel Regional Hospital Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Months Days Hours **Funeral** 1924 England 1 M 2 □ F March 16 Yrs 261-54-6814 84 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State Pages 1 and 2 should be filed within 72 hours after death with the Marylar ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner mast to notified at 1 ☐ Yes 2 ☐ No Beltsville MD Prince George Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20705 11208 Montgomery Road by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 11. Marital Status 1 ☐ Never Married 2 ☐ Married Specify: white 1 ☐ Yes 2 ☐ No Specify: Baltimore, Maryland 21215-0036 3 Widowed 4 Divorced Year or Dates 16b. Kind of Business/Industry Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) airline College (1-4or 5+) Elementary/Secondary (0-12) crew scheduler 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) maiden name Barton unknown ို 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11208 Montgomery Rd., Beltsville, MD 20705 Department of Health a Important: If item 27 is any injury or other tra Jane Mitchell (spouse) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition George Washington Cem. 10-22-08 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hyattsville, MD 22. Name and Address of Facilit Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee Parge Harght Sterbert P.O. Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final a <u>Alzheimer Disease</u> **Physician** disease or condition resulting in death) Due to (or as a consequence of): /Medical Examiner Chronic Heart Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed Hypoxia use as the burial-tran attending physician and Due to (or as a consequence of): Physician/Medical Meningitis 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23d. Date of delivery Year 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Month 5 Other (specify) 1 □ Yes 2 📉 No 9 Unknown certificate has been signed by the rector, page 2 should be detached 9 TUnknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🙀 Unknown ģ Hydrocephalus with V-P shunt Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Respiratory autopsy performed? 1 TYes 2 No 1 ☐ Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Inpatient 1 Yes 2 No Certification: To this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b Time of 28c. Injury at Work? 27. Manner of Death 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation

Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate After t within 24 hours after death To the Funeral Director:

State

Medical

Informio 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ikechukwu D. Mbonu, M.D., 300 Armory Place, Suite 3G, Baltimore, MD 21201

QCT 2 2 2008

6 Could not be determined

3 Suicide 4 Homicide

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

29a. Certifier

32 Registrar's Signature

and manner stated.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

UN MA

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D0059649

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Oct. 21, 2008

# Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

		For State Registrar		State of Mar	-	epartment of F C <i>ertificate of I</i>		vientai my	Reg. No.	008	33635	
		1. Decedent's Name	e (First, Middle, La	st)				2. Date of De	eath Day	Year	3. Time of Death	
Physicia /Medic		Mary Ma	argaret M	arx				Octobe		2008	8:15 PM M	
Examin		4a. Facility Name (If	f not institution, giv	e street and number)			Location of Death			ounty of Death		
			Rosa Nurs				nellville				eorge's	
Funeral		5. Social Security Nu	1	□ M 2M E	(In yrs. last birth	Months   Davs	If Under 24 Hrs. Hours Min.	(Month, D			place (State or Foreign intry)	
Director		393-20-8 Usual Residence of	3696	- ··· - <del>X</del> ·	87 <sup>Y</sup>			May 16	<u>. 1921</u>	Wisc	onsin	
land bw		10a. State	10b. County	1	10c. City, Town	or Location					10d. Inside City Limits	
Mary -f sh	ţ	MD	Prince	George's	Bowie						1 □ Yes 2 □ No	
r 28a notif	Director	10e. Street and Num	mber			10f. Zip Code			10g. Citizen	of What Cou	intry?	
3a o		12500 Sh	etland La	ane		20	715		U	SA		
deatl	Funeral	11. Marital Status		12. Was Decedent Ev Armed Forces?	er in U.S.	13. Was Decedent of H	lispanic Origin? (Span Mexican Puerto	pecify Yes or N	0- 14.	Race - Amer Black, White		
filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ent, Ite Medical Examiner must be notified at	þ	1 📉 Never Marrie 3 □ Widowed	ed 2 Married 4 Divorced	1 ∐Yes 2 No If Yes, Give Year or Dates:		1 ☐Yes 2 🕅 No	Specify:	Triodit, etc.,			hite	
iin 72 ho n "natur redical	Completed		15. Decedent's Edify only highest gra	ducation ade completed) College (1-4or 5+)	(	Decedent's Usual Occup Give kind of work done of life. DO NOT use retired	during most of work	king	16b. Kind	of Business/li	ndustry	
d with giene er tha	E O	Elementary/Secor	ridary (0-12)	0		nurse			hea	lthcar	e	
e file al Hy I othe vent,	Be (	17. Father's Name (					18. Mother's Nam	ne (First, Middle	e, Maiden Sui	rname)		
Ment Ment arkec	ဥ	George N	Marx				Deli	la Corbe	eau			
and 2 should be ealth and Mental n 27 is marked oner traumatic ev		19a. Informant's Na	ame/Relationship ( e Marx/sc			Mailing Address <i>(Street</i> 2500 Shet1a:					ip Code)	
permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any Injury or other traumatic event, It e Medical once.				Removal from State	20b. Place of I cemetery	Disposition (Name of crematory or other place	ce)	Date	20c. Locat	tion - City or I	Town, State	
permit. Departn Importa any Inju		21. Signature of Fu	onald S.	Wade Dire	ctor	22. Name and Addre State An	ss of Facility atomy Boa e, MD 21		W. Ba	ltimor	e Street	
		23a. Part . Enter th	he disease, or com	plications that caused the one cause on each line	he death. Do no	ot enter the mode of dyir	ng, such as cardiad	or respiratory	arrest,		Approximate Interval Between	
Physician		Immediate Cause (	(Final	Hulana		ve Cono	Liovasc	- la	a Dis	Par	Onset and Death	
/Medical		resulting in death)	•	a. Due to (or as a	consequence of			200	CVID	Con	Jeans	
Examiner	er	Sequentially list cor	nditions,	b. Demo	entic consequence of	1					years	
e be executed rsician and burial-transit	Examiner	Sequentially list cor if any, leading to im- cause. Enter Under Cause (Disease or that initiated events resulting in death) L	5	· Ata	consequence of	Fihal	lation	~			years	
ficate be executed physician and s the burial-transit	edical E	,	l	d Coron	any	Arten	y D	15-80	m		years	
To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months? ☐No	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at t	Fetal death	3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	ey		230	d. Date of deli Month	ivery Day Year	
quires that en signed buid be deta	Ď	Part II. Other signif	ficant conditions	contributing to death but	not resulting in	the underlying cause giv	ven in Part I.		tobacco use		the cause of death? obably 4 ☐ Unknown	
r <b>sician:</b> The law re s certificate has be lirector, page 2 sho	Completed								opsy formed?	prior to death?	topsy findings available completion of cause of	
ian: artifica ctor, I	Be C	25. Was case referrexaminer?	red to medical				26. Place of Dea	ath (Check only	one)			
hysic his ce I dire		1 ☐ Yes 2	No	Hospital: 1 Inpatien		patient 3 DOA Oth	ner: 4 Nursing H	lome 5 Res	sidence 6	Other (Spe	cify)	
nding Pl th. : After the	ation:	27. Manner of Deatl 1 X Natural 2 ☐ Accident	th 5 Pending investigatio	28a. Date of Injury (Month, Day,	Year) 28b. Ti	jury Wor	ryat k? ]Yes 2 □ No	28d. Describe	how injury o	occurred		
l or Atte after dez Director d in by th	Certification: To	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined			m, street, factory, office			(Street and I own, State)	Number or Ru	ıral Route Number,	
e Hospita 24 hours Funeral etely filled	Medical C	29a. Certifier (Check only one)		hysician: To the best of miner: On the basis of and manner state	examination and							
To the vithin To the Somple	Me	29b. Signature and				29c. Licens				signed (Monti		
F > F 0		) KK	a Kol	-andi	of n	10 10	0108	>	101	1910	78	
		30. Name and addr	ress of person who	completed cause of de	ath (Item 23a) (	Type, Print)	FOXLN,	222,1	BOWIE	MD	20715	
Sta Registr		31. Date filed (Mon	oth, Day, Year)	32 Registrar	r's Signatture	Grantes						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) **Physician** 20, 2008 4:20 A.M October | Matthews /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Look About Manor Westminster If Under 1 Year | If Under 24 Hrs. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1 ☑ M 2 ☐ F Maryland Director 216-16-5484 1921 87 Aug. 11. Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Department of Health and Mental Hygiene. Important: If Item 21s or 28a-f show important: If Item 21 is marked other than "natural", or Items 23a or 28a-f show important: If Item 27 is marked other than "natural pencified at once. Westminster 1 ☐ Yes 2 No Maryland Carroll Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21158 USA 1510 Stone Road Funeral Pages 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 2 Yes 2 ☐ No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Completed by Yes. Give 3 Midowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Wood Products Purchasing Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be H. Paul Matthews, Sr. Rose Sears ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24017 1674 Sigmon Road; Roanoke, VA Lynn Davis Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 10/23/2008 Woodlawn, Maryland Woodlawn Cemetery 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Euneral Service License, In di 1901490 1639 Edmondson Avenue; Catonsville, MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician OVGRANL resulting in death) /Medical Due to (or as a conse pence of): Examiner Sequentially list conditions, if any, leading to innine diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed signed by the attending physician and d be detached for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 5 Other (specify) 1 □Yes 2 □No 9 Unknown 23e. Did tobacco use contribute to the cause of death? significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably certificate has been s rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 ☐ Yes 2 No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) MINIMO Other: 4 \(\sum \) Nursing Home \(\frac{5}{\subset}\) Residence 2 1 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 6 Other (Spe 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

A Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signature and tipe of certifie 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who comple Phillip Ruzbarski,

31. Date filed (Month, Day, Year) 2008

1.D., 125 Airport Drive Suite 34, Westminster, MD 21157

d cause of death (Item 23a) (Type, Print)

Registrar's Signature

Amend #26 per MD g884 10/22/08 TT Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			epartment of Health and M Certificate of Death	lental Hyglen Reg.Ν	ZHUB 33001/
Physic	ian	1. Decedent's Name (First, Middle, Last)  Carrie Mitchell			ay Year 7.11 A M
/Medi Examir	cal	4a Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	CC 10 - 07	c. County of Death
e"		3943 Southern Cross Drive  5. Social Security Number 6. Sex 77. Age (In yrs. last birth	day) If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	Baltimore  9. Birthplace (State or Foreign
Funeral Director		216-24-7174 10M 20F 81 Y	rs. Months Days Hours Min.	Month, Day, Yea.	26 Maryland
yland how		Usual Residence of Decedent  10a. State  10b. County  10c. City, Town	or Location Battimore		10d. Inside City Limits 1 ☐ res 2 ☐ No
the Mar 28a-f s	Director	Maylard N/H  10e. Street and Number	10f. Zip Code	10g. C	Citizen of What Country?
ath with 23a or	ral Di	1940 W. Lexington St.	21223	a iif . Va a a n Na	USA 14. Race - American Indian,
Dalfill Dore, INIGIT y I all Q L L 13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any highly or other traumatic event, the Medical Eventral mist be notified at any night of the traumatic event, the Medical Eventral mist be notified at once.	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes, Give Year or Dates:	<ul> <li>13. Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto</li> <li>1 □ Yes 2 □ No Specify:</li> </ul>	ecity res of No- Rican, etc.)	Black, White, etc.  Specify: Black_
vithin 72 ho	Completed	(Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)  Superius 07	ing 1	Kind of Business/Industry
yiarid 212  uld be filed withi Mental Hygiene, arked other thar atic event, that	Be Co	17. Father's Name (First, Middle, Last)		e (First, Middle, Maide Newman	
arylan	10	William Herndon  19a, Informant's Name/Relationship (Type, Print)  19b.	Mailing Address (Street and Number or Ru.		41000
e, Ma 1 and 2 s Health ar em 27 is wher trau		Wendell Mitchell-husband 19	40 W, Lexington	- /	Himore Maryland Location - City or Town, State
more		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State  4 ☐ Donation 5 ☐ Other (Specify)	Disposition (Name of , crematory or other place)  Forest Vet, Cem. 10	1	rings Mills, Maryland
Dallino  permit. Pages Department of Important; If if any injury or once.		21. Signature of Funeral Service Licenses  Farkly  Farkly	22. Name and Address of Facility Par 3572 Frederick Ave		
	28	23a. Part 1. Enter the disease, or complications that caused the death. Do n shock, or heart failure. List only one cause on each line.  Immediate Cause (Final		or respiratory arrest,	Approximate Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)  Due to (or as a consequence or	ancer n:		
<sup>→</sup> Examiner		Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of	of):		
ecuted and -transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  C	)f)·		
ob (ou), ficate be executed physician and s the burial-transit	edical E	d			
<b>BOX 68</b> Jeath certifica attending phase as the		IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant			23d. Date of delivery
O. BOX he death ce the attendii	Physician/M	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month Day Year
ecords, P.O. BOX (law requires that the death certiles been signed by the attending 2 should be detached for use a	\$	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.		co use contribute to the cause of death? 2 ☐ No 3 ☐ Probably 4 ☑ Unknown
<b>~</b> 0 <b>~</b> 0	Completed		=	24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death? No 1 □ Yes 2 ₩ No
VITAL FIGERIAL CERTIFICATE PECTOR, pag	BeC	25. Was case referred to medical examiner?  Hospital:	Other:	th (Check only one)	v DAughter's House
og Phys rer this	n: To	27 Manner of Death 28a, Date of Injury 28b, 1	ime of njury at Work?	ome -5 Residence 28d. Describe how in	(-F)
DIVISION Of VITA  To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifical completely filled in by the funeral director;	Certification: To	2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, fa building, etc. (Specify)	M 1 □ Yes 2 □ No rm, street, factory, office	28f. Location (Stree City or Town, S	t and Number or Rural Route Number, tate)
Hospital 24 hours a Funeral I	Medical Ce	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination are and manner stated.	s, death occurred at the time, date and plac d/or investigation, in my opinion, death occ	e, and due to the caus urred at the time, date	se(s) and manner as stated. and place, and due to the cause(s)
To the within To the comple	Med	29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)
5		30. Name and address of person who completed cause of death (Item 23a)	H45931	C	MD 21113
<i>y</i>			STREET REISTER	TOWN	MD 21113
S Regis	tate trar	31. Date filed (Month, Day, Year)	Sparker		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-07764 State of Maryland / Department of Health and Mental Hygiene David Wayne McLean Certificate of Death 1- For State Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ 1039 hrs October 15, 2008 Medical Examiner David Wayne McLean 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore County** Gien Arm 11417 Notchcliff Road Date of Birth(MM/DD/YYYY)Birthplace (State or If Under 1 Year | If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Months Hours 03/18/1966 Country) MD 216-76-5189 42 Director Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State Yes 2 No MD Baltimore Glen Arm or items 23a or 28a-f show must be notified at once. Director 10g. Citizen of What Country 10f, Zip Code 10e, Street and Number 11417 Notchcliff Rd. 21057 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, 12. Was Decedent Ever in U.S. Funeral 11. Marital Status White, etc. Armed Forces? Never Married Married White Yes Specify Yes 2 No specify: permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", o injury or other traumatic event, the Medical Examiner in injury or other traumatic event, the Medical Examiner in the medical Examiner in the Medical Examiner 4 Divorced If Yes. Give Year Widowed 2 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed H/VAC Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Mechanic 12 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Louise Norma Ruth Joseph Lee McLean III Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) 2 96 Delmar Ave. Brenda Lee Kelly/Sister Balti. MD\_21222 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, OCt. 15, 20a. Method of Disposition

1 Burial 2 Cremation 3 crematory or other place) Beltsville, MD Removal from State 2008 Chesapeake Crem. Other Specify Donation 5 22. Name and Address of Facilit CAFA Stephen D.Lohrmann P.A. 21 Signature of Funeral Service Licenses M01443 8717 Green Pastures Dr. Balt. 23a. Part i) Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Onset and **Physician** failure. List only one cause on each line Death Medica Narcotic (heroin) intoxication Immediate Cause (Final disease .aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last signed by the attending physician and 1 be detached for use as the burial - transit executed 23a,27,28a-f per ME g884 10/23/08 Physician/Medical X UNPENDED The law requires that the death certificate be 23d. Date of delivery Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE: Year Month Day 3 Ectopic pregnancy 23b. Was decedent pregnant in the Fetal death Live birth past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. Yes 2 No 3 Probably 4 V Unknown Ď 24b. Were autopsy findings available Completed 24a. Was an has been s prior to completion of cause of autopsy performed? death? 1 🗸 Yes No Yes 2 26.Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certificompletely filled in by the funeral director, 25. Was case referred to medical Be Other<sub>4</sub> Residence 6 V Other: Scene Hospital: Nursing Home 5 examiner? FR/Outpatient 3 Inpatient 2 1 Yes No 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 27. Manner of Death Certification: Yes 2 X No Natural am Pending Fnd 10.15.0\$ Fnd 10:30 Investigation 2 Accident 28f. Location (Street and Number or Rural Route Number City or Town, State) 1141/Notchcliff Rd GLen Arm, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc. X Could not be 3 Suicide found at home (Specify) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 1 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

Ø

State Registrar

Jack Titus MD. Deputy

State (Nonth, Day, Year)

2 2 2008

30. Name and address of person who completed cause of death (Item 23a)

Deputy Chief Medical Examiner

32. Registrar's Signature

October 16, 2008

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October 18, 2008 MAINS MARILYN 8:40 A M 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Baltimore GreaterBaltimore Medical Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months | Days | Hours | Min. | 11/18/19/29 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 1 □ M 2 X F 78 212-30-3404 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 □Yes 2 No BALTIMORE BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21209 USA 7013 TOBY DRIVE 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 ☐ Yes 2 📆 No
If Yes, Give
Year or Dates: Black White etc 1 Never Married 2 Married 1 □Yes 2 No WHITE Specify: 3 XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) IDA **ISEKOFF HERMAN** SIRKIS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7013 TOBY DRIVE, BALTIMORE, MD LISA MAINS / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ABurial 2 ☐ Cremation 3 ☐ Removal from State BALTIMORE HEBREW 10/20/2008 REISTERSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final neumoni disease or condition resulting in death) Due to (or as a consequence of): estrue heart failure Cong Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 Tyes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy performed? 1 □ Yes 2 □ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital:

Physician /Medical Examiner

physician and the burial-transit

attending pl

been signed by the should be detached

cate has t

certificate

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

The law requires that the death certificate be executed

Box 68760,

P.O.

Records,

Division of Vital

**Physician** 

/Medical

Director

Funeral

þ

Completed

Be

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Physician/Medical Examiner

\$

Completed

Be

Certification: To

Medical

**Examiner** 

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Medical Expriner and the notified an once.

Baltimore, Maryland 21215-0036

if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

25. Was case referred to medical examiner? 1 Yes 2 No

28a. Date of Injury (Month, Day, Year) 5 Pending investigation

Inpatient 2 ER/Outpatient 3 DOA 28b. Time of

28c. Injury at Work?

28d. Describe how injury occurred

203

29a. Certifier

 Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined

Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one)

27. Manner of Death

1 Natural 2 ☐ Accident

3 Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 ☐ Yes 2 ☐ No

29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 ☐ Could not be

29c. License number

Charles

29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year) 22 OCT 2008

Dnegan Bal 32. Registrar's Signature

amend #5 Per INF G884 10/29/08 JH State of Maryland Department of Health and Mental Hygiene

10:00A M

N/A

MD

10d. Inside City Limits 1 Yes 2 □ No

21202

Approximate Interval Between Onset and Death

nus

Year

1011

Registrar

DHMH 17 Rev 1/2001

State

1650 ONLEANS ST 1751-

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Date filed (Month, Day,

Year)

FNRKLGEL -

32. Registrar's Signature

			1 - For Amend Registrar	Item	State (	of Marylary This	884,839 Ce	admen 25769 rtificati	tof H e of L	ealth a	and M	lental Hy	giene Reg. No.	00	8	33641	
	Physicia	an	1. Decedent's Name (First, Middle	e, Last)								2. Date of De. Month	ath Day	Y	ear	3. Time of Death	
1	/Medic	al	Mary Pierre			m has)		4h Cihr	Town or	Location o	of Doath	Octobe		County of		9:30 a. M	
7	Examin	er	4a. Facility Name (If not institution  Maria Health								_	yland					
	Funeral	1	Social Security Number	6. Sex			rs. last birthday,	If Under	1 Year	If Under	24 Hrs.	8. Date of Birt	th V Voerl	. 9	. Birthp	lace (State or Foreign	7
	Director		219 01 4629	1 🗆 M	VI 2€ F		89 Yrs.	Months	Days	Hours	Min.	02/108/1	1919			ryland	
	pue *		Usual Residence of Decedent  10a. State 10b. County			10c.	City, Town or L	ocation							1	0d. Inside City Limits	
	f sho	Į.	MD				Baltimo	re								1 ☐ Yes 2 ☑ No	1
	r 28a-	rect	10e. Street and Number					10f. Zip	Code				10g. Citi	zen of Wha	at Cour	ntry?	
	th with	ai D	6401 N. Char	les	St.				212	12			USZ	A			
	- ma	Funeral Director	11. Marital Status			cedent Ever in	n U.S. 13.	Was Deced	ient of Hi	spanic Ori	gin? (Sp.	ecify Yes or No Rican, etc.)	•	14. Race - Black,			
36	s afte	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced		1 ☐ Yes If Yes, G Year or	2√ No live		1 🗆 Yes	2CXX	Specify:				Specify:	Wh	ite	
21215-0036	within 72 hours after death with the Maryland ene. then *natural; or items 23e or 28a-f show the Madical Examiner must be notified at	ed t	15, Deceden			Dates.	16a. Dece	dent's Usua	al Occupa	ation			16b. Ki	nd of Busir	ness/In	dustry	
215	hin 72 in • na Madir	Completed	(Specify only highe Elementary/Secondary (0-12)		completed	(1-40r 5+)X	(Give	kind of wo DO NOT u	rk done d se retired	during mos ()	t of work	ing	Da	roahi	21	School	
21	or the	Com				Degree	2	eache							aı.	SCHOOL	
nd	be filk d oth	Be	17. Father's Name (First, Middle,	Last)								e (First, Middle,					
Z	d Men narke	2	William Clif  19a. Informant's Name/Relations			nan	19h Mail	ina Addross	/Stroot :			Cather:			ato Zir	Codel	_
Maryland	id 2 sl Ith an 17 is r traur		Bernice Fei			SSND		401 N					•	re, M		21212	
ē,	s 1 ar f Hea item other		20a. Method of Disposition			20	p. Place of Disp	osition (Nar	ne of	(9)	- 1	Date	20c. Lo	cation - Ci	ty or To	own, State	_
E	Page nent o int: If		1 Burial 2 Cremation 4 Donation 5 Other (S	Specify)		n State	Donati		mor prac								
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-1 show eny injury or other traumatic event. The Madical Examiner must be notified at once.		21. Signature of Funeral Service	icensee	ie,	irect		state Baltin		-	Boar 212	<b>d 655 W</b> 01	. Ва	<b>l</b> timo	re	Street	
	· <b>y</b> A4		23a. Part1. Enter the disease, or shock, or heart failure. List	r complica	ations that	caused the d							rrest,			Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition			1	lerate	Cand	na lu	alun	P 0	150000				Onset and Death	
A.	/Medical Examiner		resulting in death)			(or as a con		1	7	-	<u> </u>						_
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Ć	execu in and ial-tra	Examiner	that initiated events resulting in death) Last	c.	Due to	(or as a cons		3 ( )			-						
8760,	cate be executed obysician and the burial-transit			Ld.													
9	artifica ing ph e as th	Physician/Medicai	IF FEMALE:					<u>.</u>									
Box	death certific e attending p id for use as i	ian/	23b. Was decedent pregnant in the past 12 months?	230	1 Live	utcome of pre	etal death 3	Ectopic pr					4	23d. Date o Month		ery Day Year	
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	law requires that the de as been signed by the a 2 should be detached f	by Ph	Part II. Other significant conditi	ons contr	ibuting to	death but not	resulting in the	underlying c	ause give	en in Part I		23e. Did t	obacco u	se contrib	ute to t	he cause of death?	
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000	e taw requii has been s je 2 should	piet										24a. Was	nev .	24b. We	re auto	psy findings available	)
ĕ	The ete h page	Completed										perfo	rmed 2 No	dea	ath?	2 No	
/ita	ysician: The is certificete hadirector, page	Be	25. Was case referred to medica examiner?	-					Lou		of Deat	h (Check only o	опе)				
<del>6</del>	Physician: this certific	P	1 ☐ Yes 2 ☐ No  27. Man or of Death	Но		Inpatient 2 of Injury	28b. Time			4 X 140	irsing Ho	ome 5 Resi				(y)	
LO	ding h. After funer	tion	1 Natural 5 ☐ Pendir		(Mo	nth, Day Yea	) Injury	M	8c. Injury Worl	yat k? Yes 2□	No	200. Describe	now injur	y occurred			
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	To the Hospital or Attanding Ph within 24 hours efter death. To the Funeral Director: After th completely filled in by the funeral						knowledge, dea										
	thin 2- thin 2- the F	Medicai	29b. Signature and title of certifie		and ma	nner stated.				e number						Day, Year)	
<b>.</b>	with To		255. Signature and title of certifie		12 1	order	(W)		Nous		007	8673	- 14	1		300 8	
			30. Name and address of person	-			1		r ILCOYET	A.			001	المحددا	1	NG O	_
			Neal Friedla	_			01 N. C		s St	. 5t	h fl	Loor To	owsoı	n, MD	21	204	
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1			1 - For State Registrar	State of Maryla		irtment of tificate of		,	giene Reg. No. 00	8 33642
	Physici /Medio Examin	al	Decedent's Name (First, Middle, Last)     KENDET      4a. Facility Name (If not institution, give st	reet and number)	ova	4b. City, Jown,	or Location of Deal	2. Date of Dea	4c. County-	3. Time of Death 720 Am
	Funeral Director	CI	5. Social Security Number 6. Sex 1132	7. Age (In y	SP (7-5/ rs. last birthday) 78 Yrs.	If Under 1 Yea Months Days	r If Under 24 Hrs	8. Date of Birt	th y, Year)	9. Birthplace (State or Foreign Country) KS
	e Maryland Sa-f ehow	Director	Usual Residence of Decedent           10a. State         10b. County           MD         Howard		City, Town or Lo Laurel	cation				10d. Inside City Limits 1 ☐ Yes 2/5/t/No
	72 hours after death with the Maryland natural', or itams 23a or 28s-f ehow dical Examiner out he mullied at	Funeral Dire	10e. Street and Number  8449 Old Columbia  11. Marital Status	. Was Decedent Ever in	ı U.S.   13. y	10f. Zip Code 20723 Vas Decedent of	Hispanic Origin? (S	Specify Yes or No-	10g. Citizen of WIUSA - 14. Race	- American Indian,
-0036	72 hours after "natural", or ita dical Exemina	by	1 Never Married 2 图 Married 3 Widowed 4 Divorced	Armed Forces? 1 ⊠Yes 2 □ No19 If Yes, Give Year or Dates:	49	Yes, specify Cu		to Rican, etc.)		, White, etc.  white
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Maryland	d 2 should be file th and Mental Hyg 7 ie marked othe traumatic event,	To Be	Henry Fred Novak  19a. Informant's Name/Relationship (Type	ə, Print)	19b. Mailin	g Address (Stree	Ella Ma	e King	Maiden Sumame er, City or Town, S	
Baltimore, M	ss 1 an of Heal item 2 r other		Frances Ellen Robin  20a. Method of Disposition  1 Burial 2 Ocremation 3 Re 4 Donation 5 Other (Specify)	moval from State	o. Place of Dispo-	sition (Name of natory or other pl	Oct.	Date		city or Town, State
Baltin	permit. Page Department i important: if any injury or once.		21. Signature of Funeral Service Licenses	MOl	053 31	Name and Add	ress of Facility Do	naldson Laurel,	Funeral MD 20707	Home, P.A.
8760,	Physician /Medical Examiner physician and physician and physician and physician it is the physician in the physician in the physician in the physician in the physician physicia	dicai Examiner	23a. Papt. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last  d. d.	cause on each line.	sequence of):	907	. ^	avet disc	/	Approximate Interval-Between Onsel/and Death
P.O. Box 6	law requires that the death certifica as been signed by the attending ph 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	c. If yes, outcome of prediction of the control of	etaf death 3	Ectopic pregnan Other (specify)	су		23d. Date Mont	of delivery th Day Year
Records, P	w requires that been signed I should be det	ρ	Part ff. Other significant conditions conti	ibuting to death but not i	resulting in the ur	nderlying cause g	iven in Part I.	23e. Did to		bute to the cause of death?  B Probably 4 Unknown
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Division of Vi	this al dir	Certification: To B	examiner?  1 Yes 2 No  27. Manner of Death  1-Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of fnjury (Month, Day Year)		28c. Inj W M 1[	then: 4 Nursing Hury at ork?  Yes 2 No	dome 5 ☐ Resident 28d. Describe h	dence 6 Other	d
Divi	To the Hospitel or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer	al Certiff	4 Homicide determined  29a. Certifier 1—Certifying Physi	28e. Place of Injury - A building, etc. (Spe	ecify)	occurred at the	time, date and place	City or Tov	vn, State)	r or Rural Route Number,
	To the Ho within 24 to To the Fu completely	Medical	(Check only 2 Medical Examine one)  29b. Signature and title of certifier	or: On the basis of exam and manner stated.	ination and/or inv	estigation, in my	opinion, death occ	urred at the time,	date and place, ar 29d. Date signed	(Month, Day, Year)
į	15+1		30. Name and address of person who con	pleted cause of death (I	tem 23a) (Type,	Print)	4161	To Pa	DCT 1	9, 2008 25 mM21044
3.0	Sta Registr		31. Date filed (Month, Day, Year)  OCT 2 2 2008	32. Registrar's Sig	gnature	3	- Jeza	1000	( OIMP	W118101 CO//

State of Maryland / Department of Health and Mental Hygiene 33643 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Eldon John Paul

4a. Facility Name (If not institution, give street and number) /Medical OCT 2008 20.24 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince George's Takoma Park If Under 1 Year | If Under 24 Hrs. Washington Adventist Hospital last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 ★M 2 □ F 56 558-94-7636 25, 1952 California Director JUL Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show a or 28a-f sho t be notified a 1 ☐ Yes 2 XNo Director Maryland Prince George's Bowie 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 20720 11304 Booth Bay Way ns 23a o must b Pages 1 and 2 should be filed within 72 hours after death went of Health and Mental Hygiene. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: ral", or Items 2 Examiner mus 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 3 ☐ Widowed 4 ☐ Divorced White er than "natura the Medical E Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
This De Not we strict t
Foreign Service 16b. Kind of Business/Industry
Internal Revenue 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 7 Is marked othe traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elza Eileen Kramm John Paul ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 980 S. Ridgemark Dr., Hollister, CA item 27 l Elza Paul/Sister 20b. Place of Disposition (Name of cemetery, crematory or other place)
Chesapeake
Crematory, Inc. Date 20c. Location - City or Town, State 20a Method of Disposition permit. Pages Department of Important: If its any Injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/18/2008 Beltsville, MD 22. Name and Address of Facility
Rapp Funeral & Cremation Services 21. Signature of Fine at Service Licenses moores 2 933 Gist Ave., Silver Spring, MD of enter the mode of dying, such as cardiac or respiratory arrest, 20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PANCREATITIS HEMORRHAGIC **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) sician and burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Exami Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical the attending for use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à ACUTE RENAL 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an HYPERTENSION ate has bage 2 s performed death? 1 ☐ Yes cate 2 2 No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) cert Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ER/Outpatient 3 DOA ٩ 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After Injury 5 ☐ Pending investigation within 24 hours after control to the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and Alle of Pertifier 29c. License number 29d. Date signed (Month, Day, Year) D59121 M.D 312008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7600 CARROLL PARK MD 20912 T.MALTK AVE TAKOMA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 22 2008 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year Month **Physician** JOEL 1 . OCTUBER 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Under 1 Year | If Under 24 Hrs. Bon Secours Hospital 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Days Hours Months 1 ☑ M 2 □ F unk 69 Director May 4, 1939 224-40-9572 Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. In the Plant is a marked other than "natural" or items 23a or 28a-1 show Important: If item 7 is marked other than "natural" or items 23a or 28a-1 show any injury or other traumatic event, It is Mexical Examiner must be not ty⊡Yes 2 □ No Director Baltimore MD10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21223 USA 1923 Lemmon Street Funeral unk Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 □Yes 2X No Specify: black Specify: þ 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) none disabled unk unk 18. Mother's Name (First, Middle, Maiden Surname) unk 17. Father's Name (First, Middle, Last) ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health ar 2000 W. Baltimore Street Baltimore, MD 21223 Bon Secours Hospital altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4□Donation 5 NOther (Specify) in state 21. Signature Fun 1 Service Lice State Anatomy Board 655 W. Baltimore Street Wade Director Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician PNUEMONIA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Physician/Medical Examiner cause. Enter Underlying Cause (Disease or injury that initiated events law requires that the death certificate be executed ARTERIOSC LEROTIC and burial-tra resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, cate has been sign page 2 should be HYPERTENTION 1 Yes 2 No 3 Probably 4 Unknown Be Completed DBSTRUCTIVE LUNG DISEASE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No certificate RENAL 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗷 No Medical Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 X Naturai 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: △ 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 29a. Certifier 1 🕽 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D 23300 October 12 2008 -4D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 300 56 cours 3 705%.

SUDHIE PATEL, 2000 W. 13 A 2 TU, 55 BA2 TO MD. 21223 SUDHIR EL. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Amend 29c, perverbal G884 10/22/08 TT Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. / 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 3:26 PM RICHARD THOMAS RAMAGE October 20 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore City BALTIMORE VA MEDICAL CENTER BALTIMORE 8. Date of Birth (Month, Day, Ye. Jan. 21, If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Year) 1942 Pennsylvania **Funeral** 1/2 M 2□ F 66 220-38-6007 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b. County 1 □Yes 2 TX No Maryland Baltimore Lansdowne Director 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 2803 Hammonds Ferry Rd. 21227 United States Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 X Yes 2 No If Yes, Give 59-62 Year or Dates: 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify. Specify: White 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Retail Sales Sales Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Kenneth Leeland Ramage Emily Pearl Sayre 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 701 Theresa Ave., Glen Burnie, Maryland 21061 Gloria E. Baldwin / Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) Oct. Data 3, 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Crownsville MD Vet. Cem. Crownsville, Maryland 4 Donation 5 Other (Specify) 21. Signature of Fureral Se Kirkley-Ruddick Funeral Home, P.A. 421 Crain Hwy., S.E., Glen Burnie, MD 21061 ce Licensee B Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition **Physician** SEPTICEMIA disease or condition resulting in death) /Medical Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 | Yes 2 | No 3 | Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1□ Yes 2¶ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Nnpatient 2 ER/Outpatient 3 DOA P 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) Injury 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No

Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-tran Division or Vital Records, P.O. Box 68760, attending physician for use as the buria ed by the a been signed by should be detac page 2 s certificate rthis c I Director: After to in by the funera death.

Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene. ant: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show ary or other traumatic event, the Medical Examiner must be notified at

permit. Page Department o Important: If any Injury or

Baltimore, Maryland 21215-0036

Certification: Medical

within 24 hours a To the Funeral I 10

PRIYA 31. Date filed (Month, Day, Year) State

3 ☐ Suicide

(Check only one)

29b. Signature and title of certifier

29a. Certifier

6 ☐ Could not be determined 4 Homicide

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

> 29c. License number AU4176435K18920

29d. Date signed (Month, Day, Year) 10-20-2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

10 N. GREENE STREET, BALTIMORE, MD 2120 KUPPUSAMY

Congress.

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician OCTOBER 2008 TTH 7:30A /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner BALTIMORE SLADE AVENUE, APT. BALTIMORE If Under 1 Year | If Under 24 Hrs. (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 💢 F Yrs 07/31/1922 86 MD Director 213-14-8819 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State if than "natural", or items 23a or 28a-f show the Wodical Exercitor must be notified at 1 ☐ Yes 2 🕍 No Director MD BALTIMORE BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 7 SLADE AVENUE, APT. 704 21208 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∏Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 🕅 No Specify: Specify: WHITE 2 3 N Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) **FURNITURE** SECRETARY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be 1 Health and Mental LOUIS ABRAMOWITZ ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) S permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr once. 27 8 RIVER OAKS\_CIRCLE, BALTIMORE, MD <u>DEBRA ATTMAN / DAUGHTER</u> 20b. Place of Disposition (Name of cepstery, cepstary or other place)
CHIZUK AMUNO CONG. 20c. Location - City or Town, State 20a. Method of Disposition 1 Durial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/19/2008 BALTIMORE, MD 22. Name and Address of Facility 21. Signatur, o Funeral Service Licensee SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. CEREBROVAS Immediate Cause (Final Physician LULAR ACCIDENT DAYS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner HEROSCL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit law requires that the death certificate be executed and Due to (or as a consequence of): Physician/Medical the attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 ☐ Pregnant at time of death 5 Other (specify) P.O. 9 Unknown been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 1 Yes 2 No or Attending Physician: The certificate 2 🗆 No 1 ☐ Yes funeral director, 25. Was case referred to medical Medical Certification: To Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation death. 1 □Yes 2 □No 2 Accident after death the 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined within 24 hours a Hospital 1 🗴 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

29b. Signature and title of certifier

filed (Month, Day.

Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2700 32. Registrar's Signature 29c. License number

DOD 19317

29d. Date signed (Month, Day, Year)

AKE DR BARTIMORE, MD 21209

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of M	arylan	d / Dep	artmer	t of H	ealth a	and M	ental Hyg	jiene	,		
			1 - State Registrar			Ce	rtificat	e of L	Death		Я	leg. No. 2	008	3.3	3647
п	Physici	an	1. Decedent's Name (First, Middle, La	,							2. Date of Dea Month	Day	Year	3. Time o	
1	/Medic	al	Catherine Speec  4a. Facility Name (If not institution, giv		<u> </u>		4h City	Town or	Location of		October		ty of Death	3:45	PM M
y	Examin	er	Hamilton Nursin		,		1	1tim		or Douth		40. 00011	ty of Death	•	
	Funeral		5. Social Security Number 6. S	ex 7. A	ge (In yrs.	last birthday,		1 Year Days	If Under	24 Hrs. Min.	8. Date of Birth (Month, Day	Year)	9. Birth	place (State	
	Director		21/-64-1451	□M 2∏ F	55	Yrs.	Montale	Daye			Dec 27				unk
	land it		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or L	ocation							10d, inside C	City Limits
	Mary a-f sh	tor	MD		I	Baltim	ore							1X Yes	2 □ No
	ith the	Direc	10e. Street and Number		•		10f. Zi				-	10g. Citizen o	f What Cou	ıntry?	
	within 72 hours after death with the Maryland ene. ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at	Funeral Director	6040 Harford Road		Fuer in 11	C 140	Was Dess	212		inin? (Cno	oifu Van ar Na		SA ace - Amer	ican Indian	
	ter de item	Fune	11. Marital Status  1 ☐ Never Married 2 ☐ Married	12. Was Decedent Armed Forces 1 Tyes 2 X If Yes, Give	?				n, Mexicar	n, Puerto I	cify Yes or No- Rican, etc.)	BI	ack, White		
21215-0036	ral", or	ğ	3 ☐ Widowed 4 K Divorced	If Yes, Give Year or Dates:			1 ☐ Yes	2 <b>∏</b> No	Specify:			Spec	cify: w	hite	
2-0	72 ho 'natur dical	eted	15. Decedent's E (Specify only highest gra	ducation ade completed)		(Give	edent's Usu kind of we	rk done d	luring mos	t of workin	unk	16b. Kind of	Business/I	ndustry	unk
121	within lene. than he Mc	Completed	Elementary/Secondary (0-12) unk	College (1-4or	5+)	life.	DO NOT L	se retired	)						
	Hygi other ent, tl	Be Co	17. Father's Name (First, Middle, Last					unk	18. Mothe	er's Name	(First, Middle,	Maiden Surna	ame)		unk
/lan	uld be Menta Irked Itlc ev	To B													
Maryland	iges 1 and 2 should be filed within 72 hr It of Health and Mental Hygiene. If item 27 is marked other than "natu or other traumatic event, the Medical	·	19a. Informant's Name/Relationship (								Route Numbe			ip Code)	
	1 and 2 Health tem 27 I		Hamilton Nursing  20a. Method of Disposition	Center	20b. F	Place of Disp	osition (Na	me of	1		timore,	MD Z	1214 n - City or 1	Town, State	
Baltimore,	permit. Pages 1 a Department of Hee Important: If Item any Injury or othe		1 ☐ Bunal 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 🌠 Other (Specia		9	cemetery, cre	matory or	othe <i>r pla</i> c	e)		Ì		,	,	
alti	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service Lice Ronald S	nsee / / 1	ector	r 2	2. Name a	nd Addres	s of Facilit	ty	655 W.	D 0 1 + 4.		C+	
8	<b>8 3 E 6</b>		Sim !!	1 see		В	altim	ore.	MD	2120	1		nore		
			23a. Pan1. Enter the disease, or com shock, or heart failure. List only Immediate Sause (Final	plications that cause one cause on each	d the deat line.	h. Do not er	iter the mo	de of dyin	g, such as	cardiac o	r respiratory an	rest,		Approxima Interval Be Onset and	etween
	Physician /Medical		disease or condition resulting in death)	a Due to (or as	15CL	D uence of):									
	Examiner			b	. a conceq	donos on.									
ь.	pe iii	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	s a conseq	uence of):									
	and and al-trans	xam	that initiated events resulting in death) Last	c Due to (or as	s a conseq	uence of):									
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89	rtificat ng phy as th		IF FEMALE:												
Вох	ath ce ttendii or use	ian/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth	2 🗆 Feta	al death 3	□Ectopic p		,				Date of deli	very Day	Year
P.O. I	The faw requires that the death certifica tte has been signed by the attending ph tage 2 should be detached for use as th	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnanta 9□Unknown	at time of d	leath 5	Other (s	pecify)	-					,	
	that ned by	by Ph	Part II. Other significant conditions	contributing to death	but not res	ulting in the	underlying	cause give	en in Part I	l.	23e. Did to	obacco use co	ontribute to	the cause of	death?
Records,	equire en sig ould bo	ed b									1 🗆 Y	′es 2□ No	3 ☐ Pro	obably 4	nknown
ဝင္ပ	las be	Completed									24a, Was a	sy	prior to c	topsy findings	s available cause of
a H	cate to	Con									perfor 1□ Yes	2 No	death? 1 ☐ Yes	2 100	
Vital	sician certifi rector	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	: 0 =	ICD/Out-atie		OA Othe		/	(Check only of				
o	g Phy er this eral di	n: To	27. Manner of Death	28a. Date of In	jury	28b. Time		28c. Injur Worl			me 5 Resid 28d. Describe h			city)	
ion	ath. or: Aft	atio	1 ✓ Natural 5 ☐ Pending investigatio		ay rear)	Injury	М		Yes 2□	No					
Division or	I or Attend after death. Director: /	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of it	ijury - At he etc. <i>(Specii</i>		treet, facto	y, office		2	28f. Location (S City or Tow		mber or Ru	ral Route Nu	mber,
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier 1 Certifying P	hysician: To the bes	t of my kno	owledge, dea	th occurre	d at the tir	ne, date ar	nd place.	and due to the	cause(s) and	manner as	stated.	
	n 24 h	Medical	(Check only 2 ☐ Medical Exa	miner: On the basis and manner s	of examina	ation and/or i	nvestigatio	n, in my o	pinion, dea	ath occurr	red at the time,	date and plac	e, and due	to the cause	(s)
	To the Tourn	Ň	29b. Signature and title of certifier					c. Licens		_		29d. Date sig	ned (Month	n, Day, Year)	
			Igha Wi	)				057	727			101	10/08		
			30. Name and address of person who	completed cause of	death (Iter	n 23a) (Type マーフ ル	Print)	Ma	m M	VOOM	ls Ro	nd.	Mh		
	Sta	ate	31. Date filed (Month, Day, Year)	32. Renis	trar's Signa	ature	Some	200	. ) - •	- 10	- 10 00		/ 10		

DHMH 17 Rev 1/2001

			<b>Type or Print in Blac</b> State of Maryland / I		alth and Mental Hygi	
		1 - For State Registrar		Certificate of De	eath Re	eg. No. 2008 3351
Physic /Med		Decedent's Name (First, Middle, Last)     Same S     4a. Facility Name (If not institution, give si	5r	4b. City, Town, or Lo	October	Day 15 2008 254 P M  4c. County of Death
Exam	iner	The Johns Hopkins Ho		Baltimore C		40. County of Boun
Funera Directo		5. Social Security Number 6. Sex 216-44-2010		rthday) If Under 1 Year	Hours Min. 8. Date of Birth (Month, Day, Mar 28,	Year) 9. Birthplace (State or Foreign Country) 1946 Maryland
Maryland I-f show led at	tor	Usual Residence of Decedent  10a. State 10b. County  MD	10c. City, Tow	n or Location 1timore		10d. Inside City Limits 1√ Yes 2 □ No
with the 3a or 28a t be notif	al Director	10e. Street and Number 6202 Alta Avenue		10f. Zip-Code	206	og. Citizen of What Country? USA
Iryland 21215-0036 should be filed within 72 hours after death with the Maryland to Mental Hygiene. marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1   Yes 2 No If Yes, Give Year or Dates:		oanic Origin? (Specify Yes or No- Mexican, Puerto Rican, etc.)  Specify:	14. Race - American Indian, Black, White, etc.  Specify: White
21215-0036 d within 72 hours aft giene. er than "natural", or the Medical Examir	Completed	15. Decedent's Edul (Specify only highest grade Elementary/Secondary (0-12)		a. Decedent's Usual Occupati (Give kind of work done du. life. DO NOT use retired) paramedic		16b. Kind of Business/Industry healthcare
e d la be	To Be Co	17. Father's Name (First, Middle, Last)  James L. Smith Sr		1	8. Mother's Name (First, Middle, M Florence Harmo	n
Ma nd 2 s alth ar 27 is		19a. Informant's Name/Relationship (Type Terry L. Smith/sp		b. Mailing Address (Street and 5202 Alta Aver	d Number or Rural Route Number, nue Baltimore, M	, City or Town, State, Zip Code) D 21206
a 60		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 🛣 Other (Specify)	emoval from State cemete	of Disposition (Name of ery, crematory or other place)		20c. Location - City or Town, State
Baltimo		21. Signature of Emeral Service License Ronald S. W	1000	Baltimore,	MD 21201	Baltimore Street
Physician		2.a. Int 1. Enter the Jease, ir complished, or heart fillure. List only on immediat cause (Final disease or condition	cations that caused the death. Do e cause on each line.	1 1	such as cardiac or respiratory arre	est, Approximate Interval Between Onset and Death
/Medical Examiner	١.	resulting in death)  Couperfully list conditions, if the leading to immediate.	Due to (or as a consequence Due to or as a consequence	eart failure	0	yours
60, be executed cian and burial-transit	Examine	Esqueritally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence	thy		1/2 105°
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the d	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pregnancy  1  Live birth 2  Fetal deat  4  Pregnant at time of death  9  Unknown	th 3  Ectopic pregnancy 5 Other (specify)		23d. Date of delivery Month Day Year
rds, P.C luires that the signed by a	ed by PI	Part II. Other significant conditions con	ntributing to death but not resulting	7 7 1	en in Part I. 23e. Did tol	bacco use contribute to the cause of death?
Vital Records, sician: The law requires t certificate has been signe irector, page 2 should be	Completed by	Sepsis			24a. Was ar autops perform	y prior to completion of cause of
Vital sician: Ti certificate lirector, pa	Be	25. Was case referred to medical examiner?	Hospital:	Other	26. Place of Death (Check only one	No.
Physical trico	ը 2	27. Manner of Death	1 Inpatient 2 □ EH/C	Outpatient 3 DOA 28c. Injury Injury Work?	at 28d. Describe ho	ence 6 ☐ Other (Specify)  ow injury occurred
Division of Vital Rec fo the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has I completely filled in by the funeral director, page 2	Certification:	1 Natural 5 Pending 2 Accident 3 Suicide 6 Could not be determined	28e. Place of injury - At home, foulding, etc. (Specify)	M 1 □ Y€	es 2 🗆 No	treet and Number or Rural Route Number, , State)
To the Hospital of within 24 hours at To the Funeral Discompletely filled i	Medical Ce	29a. Certifier (check only one)  1 Certifying Physical Certifying Physical Examination (Check only one)	sician: To the best of my knowledginer: On the basis of examination a and manner stated.	ge, death occurred at the time and/or investigation, in my op	e, date and place, and due to the cinion, death occurred at the time, c	cause(s) and manner as stated. date and place, and due to the cause(s)
To the within To the comple	Me	29b. Signature and title of certifier		29c. License		9d. Date signed (Month, Day, Year) 2 to be 15 2008
		113	ekson, MD		600 North Wol	fe St, Baltimore, MD, 21287
Regi		31. Date filed (Month, Day, Year)	32. Registrar's Signature	Ball		

DHMH 17 Rev 1/2001

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October 19, Bertha Stavrakos 2008 6:10 A.M 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Frederick Villa Nursing Home Catonsville Baltimore 8. Date of Birth (Month, Day, Year) Sept. 30, 1936 Maryland 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Months Days Hours 1 □ M 2 🖺 F 212-40-5627 72 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Baltimore Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 903 Coleridge Road 21229 USA Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 2 XNo Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Assembly Worker Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Constantine H. Stavrakos Christina Sourgis 19a. Informant's Name/Relationship (Type. Print, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George G. Stavrakos Brother 903 Coleridge Road; Baltimore, MD 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greek Orthodox Cemetery 10/24/08 Windsor Mill, Maryland 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21. Signature of Eyneral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 9 Due to (or as a conse Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of). IF FEMALE 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably ⊌nknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performa 1 ☐Yes 2 ☐ No 1 ☐Yes 2 🗷 25. Was case referre to medical examiner? 26. Place of Death (Check only one) 2 110 Hospital: Other: 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

**Physician** /Medical Examiner

**Physician** 

/Medical

**Examiner** 

Director

Funeral

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Completed

Be

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**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ita Madical Experiment institutional training at any injury or other traumatic event, Ita Madical Experiment institutional any other profiled at all others.

Baltimore, Maryland 21215-0036

physician ar s the burial-tr ned by the attending a detached for use as has been signed by 'e 2 should be detach

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit master. Exam Physician/Medical Completed by Be Medical Certification: To

Division of Vital Records, P.O. Box 68760,

State Registra

KODOUF

29a. Certifier (Check only one)

27. Manner of Deal 1 D Natural 2 □ Accident

3 Suicide

4 ☐ Homicide

29b. Signature and title of certifier

5 Pending investigation

6 Could not be

determined

28a. Date of Injury (Month, Day, Year)

and manner stated.

1 ☐ Yes 2 ☐ No

28c. Injury at Work?

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 20/58

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Hursing Home 5 ☐ Residence 6 ☐ Other (Specify)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NR FRHANA 6

31. Date filed (Month, Day, Year) 2 2008 32. Registrar's Signature

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28b. Time of Injury

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death THOMAS JEROME SWIFT, JR. Month Year **Physician** 6:15 A M October 0 19. 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3519 Third Street Baltimore N/A If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days 1 M 2□ F 214-30-6066 73 Director Nov. 30, 1934 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must be notified at once. Maryland N/A 1X Yes 2 No Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ö USA 21225 3519 Third Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ∐Yes 2 🔀 No Specify: <u>≽</u> Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Purveyor of Fine Goods Self Employed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Catherine Frank Thomas Jerome Swift, Sr. ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) (Wife) 3519 Third St., Baltimore, Md. Vicky L. Swift 21225 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Bayview Crematory, Inc. 10/22/08 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of uneral rvice Licensee Kevin E Ecker McCully-Polyniak Funeral Home, P.A. 237 E. Patapsco Ave., Baltimore, Md. 21225-1856 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** >4-earg MOM /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit hroni Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed' 1 □Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes ②☑ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 Natural Certification: 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4710 Penneng 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 22 Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of Ma	arylaric		tificate of L	reaith and iv D <i>eath</i>	, ,	giene Reg. No. 20	08	33	551
	Physici	an.	1. Decedent's Name (First, Middle,	•					Date of Dea     Month	th Day	Year	3. Time of	Death
	/Medic			Julius Luck	iano	Simms				r 7, 20	08"	4:45	p^
	Examin	er											
spe!			13605 Engleman  5. Social Security Number		e (In yrs. la	at hirthday)	Laurel If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Princ			
	Funeral Director		214-26-2680 Usual Residence of Decedent	1 M 2 □ F	76	Yrs.	Months Days	Hours Min.	March 2	Year) 2, 1932	Coun	lace (State of try) yland	or Foreign
	/land		10a. State 10b. County		10c. City,	Town or Loc	ation				10	0d. Inside Ci	ity Limits
	a-f sh	ctor	MD Prince	George	Lau	re1						1 X Yes	2 🗌 No
	or 28	Director	10e. Street and Number				10f. Zip Code		1	I0g. Citizen of W	Vhat Coun	try?	
	ath wi	ral	13605 Engleman	Drive			20708			U.S.A.			
336	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, it. M. Midfel Event har to the inflied an once.	by Funeral	11. Marital Status  1 □ Never Married 2 ☒ Marrie 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? d ∑Yes 2 ☐ I If Yes, Give Year or Dates:	No	1	Vas Decedent of Hi Yes, specify Cuba □Yes 2∏XNo	ispanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		e - Americ k, White, e  Blac	tc.	
Ö	2 hou	ted	15. Decedent's	Education	1754	16a. Deced	ent's Usual Occupa	ation		16b. Kind of Bu			
2	thin 7 ne. <b>nan "r</b>	Completed by	(Specify only highest Elementary/Secondary (0-12)	College (1-4or 5	i+)			luring most of worki )	I				
2	led wi	S		4		Publi	c Affair	s Officer		United		es Arı	ny
anc	ould be filed v I Mental Hygie Iarked other I Iatic event, In	Be	17. Father's Name (First, Middle, L. Joshua Simms	ast)			l	18. Mother's Name		Maiden Surnam	e)		
ڇ	should and Mer s marke umatic	욘	19a. Informant's Name/Relationshi	n (Type Print)		10h Mailin	Address (Street	Estella and Number or Rura		r City or Town	Ctata Zia	Codel	
<u>8</u>	alth ar 27 is r trau		Lucille Delore		ouse			n Drive,					
ře,	s 1 and 2 of Health item 27 i		20a. Method of Disposition				ition (Name of atory or other place			20c. Location -			
<u>E</u>	Pages nent of ant: If ite ary or o		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe				Nat. Cer		17,08	Arlingto	on, V	irgini	La
Baltimore, Maryland 21215-0036	permit. Departr Importa any inju		21. Signature of Funeral Service Li	censee M010	)53	22. D	Name and Addres	ss of Facility Funeral tt Ave. L	Home, P	.A.			
The same of the sa	Physician /Medical	S 7	23a. Part 1. Enter the disease, or c shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	nly one cause on each lir	ne. Lal Ir	Do not ente	r the mode of dyin				u 207	Approximate Interval Bet Onset and I	e ween
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SOX .	eath certi attending for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1  Live birth 4  Pregnant a	2 Fetal o	death 3□	Ectopic pregnancy Other (specify)	,	7.37	23d. Date Mor	e of delive		Year
1	that the		Part II. Other significant condition	s contributing to death bu	ut not result	ting in the un	derlying cause give	n in Part I.	23e. Did tol	bacco use contr	ibute to th	e cause of d	leath?
g	w requires that the d been signed by the should be detached	ed by							12 <b>K</b> ] Ye	es 2 🗆 No	3 Prob	ably 4□ L	Jnknown
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VItal	Physician: The this certificate al director, pag	Be	25. Was case referred to medical examiner?	Harrist .			Lav	26. Place of Death	(Check only on	e)			
=	hys High	<u>۲</u>	1 ☐ Yes 2 ☐ No 27. Manner of Death			R/Outpatient		4 🗆 Nursing Ho				)	
o	iding Physician: th. After this certifica funeral director, p	tion	1 Natural 5 Pending 2 Accident Investiga	28a. Date of Inju (Month, Da)	v, Year)	28b. Time of Injury	28c. Injury Work M 1 □ Y	rat ? /es 2 □ No	28d. Describe ho	ow injury occurre	ed		
DIVISION	To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After t completely filled in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Could no determin	t be 280 Place 4 Inju	iry - m L m c. (Specir )	ne, farm, stre			28f. Location (St City or Town	treet and Numbern, State)	er or Rura	Route Num	ber,
	ne Hospit n 24 houn ne Funera pletely fille	Medical (	29a. Certifier 1 ☐ Certifying (Check only one)	Physician: To the best of caminer: On the basis of and manner sta	f examination	ledge, death on and/or inv	occurred at the timestigation, in my op	ne, date and place, pinion, death occurr	and due to the c red at the time, d	ause(s) and ma ate and place, a	nner as st	ated. the cause(s	)
	Vithi Voth	ž	29b. Signature and title of certifier	) (			29c. License	number	į.	9d. Date signed			
				4	~		D6755	58		October	16,2	800	
	141		30. Name and address of person w				1	201 0-1	ontor '	WD 0111	)	<del></del>	
	Stat	e	Mark H. Davino, 31. Date filed (Month, Day, Year)	M2 Registra	r'e Signatu	ro		201, Ud	encon, P	AD SITIS			
	Registra		OCT 2 2 20	08	S	park	Reco						

08-07751 Jac

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

cqueline Smitt	1	- For State Of Maryland / Department o		Reg. No	200	) 8 <u>336</u> 5
Physicia		egistrar  1. Decedent's Name (First, Middle,Last)		Date of Death Month Day	Year	3. Time of Death 2126 hrs
edical Exami		Jacqueline SMITH	4b. City, Town, or Location of Death	October 14, 20	008 c. County of Death	21201113
		4a. Facility Name (if not institution, give street and number)  Harbor Hospital Center	Baltimore		N	A
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)		8. Date of Birth (M)	M/DD/YYYY) 9. Birth Coui	place (State or Foreign ntry)
Director		216-84-0959 1 M 2 J	Months Days Hours Min.	July 31	, 1973 1	Maryland
any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Loca	ition	, ,		10d. Inside City Limits
		Manyland Battimore	Woodlawn			1 Yes 2 No
ie Maryland or 28a-f show fied at once.	Director	10e. Street and Number	10f. Zip Code	10g. C	citizen of What Count	ry?
th the Maryland 23a or 28a-f sho notified at once		12 Walden Holly Ct.	2)207 (as Decedent of Hispanic Origin? (Spec	rifu Vos or No-	14. Race - Americ	an Indian, Black
ath with tems 2 st be n	Funeral	1 Never Married 2 Married Armed Forces?	Yes, specify Cuban, Mexican, Puerto Ri	ican, etc.)	White, etc.	* /
fter de:  ", or i		1 Yes 2 No 1   1   Yes 2   No 1   1   Yes 3   1   1   Yes 3   1   1   1   1   1   1   1   1   1		_1 -5 17	Specify: B	CK
hours a 'natura Examir	eted by	15. Decedent's Education (Specify only highest grade completed) 16a. Decede during	ent's Usual Occupation (Give kind of wo most of working life. DO NOT use retire		. Kind of Business/Ir	idustry
36 Lhin 72 lee. than "1	plet	Elementary/Secondary (0-12) College (1-4 or 5+)	unemployed		NA	
5-0036 led within 72 Hygiene. tother than	Compl	17. Father's Name (First, Middle, Last)	18.Mother's Name (I		en Surname)	
D 21215-003 should be filed withi and Mental Hygiene. 7 is marked other tl	a	Yenneth Anderson  19a. Informant's Name/Relationship (Type, Print)  19b. Maill	ing Address (Street and Number or Ru	Jones Iral Route Number	, City or Town, State,	Zip Code) 4400
imore, MD 21215-0036  Pages 1 and 2 should be filed within 72 hours after death with the Maryland nont of Fleath and Mental Hygiest and the Maryland witt. If them 27 is marked other than "matural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once	ဥ	Daveva Smith -SISTER 12	Walden Holly	Ct. V	Voodlawn	Maryland
re, MD st 1 and 2 sho of Health and If item 27 is		cromptony or	osition (realises)	1	C. Location - City or	. 1
MOFE Pages 1 nent of F ant; If i		4 Donation 5 Other Specify:	mel Cemeral 1	24108	Battimore	Marylard
Baltimore, M permit. Pages 1 and 2 Department of Health Important: If item 2 injury or other traun		21. Signature of Fune al Service Licensee	Name and Address of Facility	er Funer	Time Du	rolland
Physician	-	23a. Part I. Enter the disease, or complications that caused the death. Do not enter	r the mode of dying, such as cardiac or	respiratory arrest,	shock, or heart	proximate Interval etween Onset and
Medita		failure. List only one cause on each line.  Immediate Cause (Final disease a. Atherosclerotic of	cardiovascular dis	ease		Death
kaminer		or condition resulting in death)  Due to (or as a consequence of):				
	jer	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
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Box 68760, ne death certificate by the attending physis hed for use as the bu	Į,	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2	Fetal death 3 Ectopic pregnar	ncy		Day Year
Box 687 (see death certifice the attending pled for use as the	sicia	past 12 months?  4 Pregnant at time of death 5	Other (Specify)		0)	
O. BC t the der by the s	Phy	Part II. Other significant conditions contributing to death but not resulting in the	ie underlying cause given in Part I.		cco use contribute to	
ires that the signed by	1 -	CHronic obstructive pulmonary dis	ease; cocaine			bably 4 Unknown
cords, law requir has been s	lete	use		24a. Was an autopsy performe	prior to	utopsy findings available completion of cause of
Reco The lav	, E			1 <b>✓</b> Yes 2		es 2 No
tal Rectian: The	Be	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ✔ ER/Outpati	26.Place of Death (Check of Death 3 DOA Other Nursing		esidence 6 Othe	er:
of Vital Records, P.O. ling Physician: The law requires that th After this certificate has been signed by functed director, page 2 should be detach	P	1 V Yes 2 No The Impatient 2 V Crossipes.  27 Manner of Death 28a, Date of Injury 28b. Time	SII. 6 201	28d. Describe how		
ion of tending Pleath.	ţ	1 X Natural 5 Pending 2 Accident Investigation (Month, Day, Year)	1 Yes 2 No			
Division pital or Attendii ours after death. teral Director: A	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, s	treet, factory, office building, etc.	28f. Location (Stre or Town, Stat		ural Route Number, City
Di Hospital 24 hours a Funeral	Sed	4 Homicide (Specify)  29a. Certifier 1 Certifying Physician: To the best of my knowledge, death or	coursed at the time, date and place, and	due to the cause(	s) and manner as sta	ated.
Division of Vital Records, P.O. Box 68760, To the Itospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Purnaral Director: After this certificate has been signed by the attending physician and completely filled in whe funeral circotor, page 2 should be detached for use as the burial - transi	Medical	(Check only one)  Certifying Physician: To the best of my knowledge, death of the basis of examination and/or invest and manager stated.	igation, in my opinion, death occurred a	at the time, date an	d place, and due to t	he cause(s)
	9	and manner stated.  29b. Signature and title of certifier	29c. License number		29d. Date signed (M	
Der		WIND MY	O.C.M.E.		October 15, 200	
Foll boun		30. Name and address of person who completed cause of death (Item 23a)  Russell Alexander MD. Assistant Medical Examiner 1	111 Penn Street, Baltimore, M	D 21201		
4	State	Page Plantage Manager Page Plantage Page Page Page Page Page Page Page P	ANT -			
Regi		COT CO 2000 A Mars	and the second	00	ME	

08-07863 Quentin Smith Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

entin Smith	4 1	State of Maryland / Department or For State Certificate or	Health and Mental Hygiene	
Dhyainia	Re	Decedent's Name (First, Middle,Last)	2. Date of Month	D. Vees
Physiciar Examin	-	Ruphtin T. Smith	Octob	er 19, 2008 O657 hrs
\	48	a. Facility Name (if not institution, give of our	4b. City, Town, or Location of Death  Gwynn Oak	Baltimore County
	4	10 Walden Maple Court Social Security Number 6. Sex 7. Age (In yrs. last birthday)		of Birth(MM/DD/YYYY) 9. Birthplace (State or
Funeral Director	5.	Social Security Number 6. Sex 7. Age (In yrs. last birmday)	Months Days Hours Min.	V 18 1997 Foreign Country) Mary land
Director	2/	Jsual Residence of Decedent		10d. Inside City Limits
any	_	Oa. State 10b. County 10c. City, Town or Local	/ 1	1 Yes 2 No
and F show	5 L	Maryland Baltimore WC	100 / ( W / )	10g. Citizen of What Country?
ith the Maryland 23a or 28a-f show any notified at once.	Director	10e. Street and Number	21207	USA
tith the		11. Marital Status 12. Was Decedent Ever in U.S. 13. W	as Decedent of Hispanic Origin? (Specify Yes	or No- 14. Race - American Indian, Black, White, etc.
eath w	Funeral	1 Never Married 2 Married 1 Yes 2 No	Yes, specify Cuban, Mexican, Puerto Rican, et	Plank
after d	>	3 Widowed 4 Divorced If Yes, Give Year 1	Yes 2 No specify:  ent's Usual Occupation (Give kind of work done	Specify: Specify: 16b, Kind of Business/Industry
hours	ᇗ	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)	most of working life. DO NOT use retired)	
36 nin 72 than "dical	Completed	College ( N/A	Student	Student
5-0036 led within 7 Hygiene other than	하	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, M	iddle, Maiden Surname)
D 21215-0036 should be filed within 72 hou and Mental Hygiene 7 is marked other than "nat natic event, the Medical Exa	8	IV / At	ing Address (Street and Number or Rural Rou	Jte Number, City or Town, State, Zip Code)
C d b is it	2	19a. Informant's Name/Relationship (Type,,Print)  19b. Mail  19b. Mail	laiden Maple Ct. u	1000 awn, MD, 21201
nore, MD 2 sges I and 2 shoul nt of Health and N t: If item 27 is n other tranmatic	l f	20a. Method of Disposition 20b. Place of Disposition crematory or	osition (Name of cemetery, Date other place)	20c. Location - City or Town, State
nor ages ent of nt: If		1 Burial 2 Ecremation 5 Removal non-State Metro	rematory, INC OCT 23)	2000 Catonsville, Maryland
Baltimore, MC permi. Pages I and 2 si Department of Health an Important: If item 27 injury or other transm		21. Signature of Funeral Service Licensee	Name and Address of Facility Parker 512 Frederick Ave.	Funeral Home, P.A.
	4	23a. Part i. Enter the disease, or complications that caused the death. Do not enter	r the mode of dying, such as cardiac or respira	tory arrest, shock, or heart Approximate Interval Between Onset and
/ Physician Medical	- 1	failure. List only one cause on each line.		Death
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	_	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):		
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Sox 68760, death certificate but e attending physic for use as the but	sician/Me	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 4 Pregnant at time of death 5	Fetal death 3 Ectopic pregnancy Other (Specify)	
Box 68760 e death certificate be the attending physical for use as the bh	ysic	1 Yes 2 No 9 Unknown g Unknown		3e. Did tobacco use contribute to the cause of death?
	by Phy	Part II. Other significant conditions contributing to death but not resulting in t	ne andenying dadde given in the	1 Yes 2 No 3 Probably 4 Unknown
Division of Vital Records, P.O. In or Attending Physician: The law requires that the staffer death.  The after death.  The this certificate has been signed by led in by the functal director, page 2 should be detact.	ed b		2	4a. Was an autopsy findings available prior to completion of cause of
ord aw req as bee 2 shou	Completed			autopsy performed? death?  ✓ Yes 2 No 1 ✓ Yes 2 No
Rec The I	Son		26.Place of Death (Check only or	V les 2 no V
<b>Tital</b> sician: is certi	Be	25. Was case referred to medical examiner?  1 Ves 2 No  Hospital: Inpatient 2 ER/Outpa	tient 3 DDA Other Nursing Hom	ne 5 Residence 6 🗸 Other: Scene
of V ig Phy frer th	1: To	27 Manner of Death 28a, Date of Injury 28b, Time	of injury	Describe how injury occurred
ion tendir cath. tor: A	ation	1 X Natural 5 Pending 2 Accident Investigation	1 Yes 2 No	ocation (Street and Number or Rural Route Number, City
ivision  Tor Attend  after death.  Director:	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)		or Town, State)
D Hospital 24 hours Funeral	<u>5</u>		occurred at the time, date and place, and due to	o the cause(s) and manner as stated.
Division of Vital Rec To the Hospital or Attending Physician: The L within 24 hours after death. To the Funeral Director: After this certificate I completely filled in by the funeral director, page	Medical	Certifying Physician: To the best or my knowledge, dealth (Check only one)  2 Medical Examiner: On the basis of examination and/or invegree and manner stated.	stigation, in my opinion, death occurred at the t	ame, date and place, and the transfer
	Me	29b. Signature and title of certifier	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) October 19, 2008
d to		WII	U.C.IVI.E.	
J. W.		30. Name and address of person who completed cause of death (Item 23a)  Jack Titus MD. Deputy Chief Medical Examiner 111	Penn Street, Baltimore, MD 21201	
7 7	State	31. Date filed (Month, Day, Year)	ache s	
Pogi		[ [ [ ] ] ] / [ [ ] A / [ ] A	No. of Contract of	

DHMH 17 Rev 1/2001 OCME 2006 ORIGINAL

DCME

Amend #2, perMD g884 10/22/08 TT
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend 4c, perMD g884 10/22/08 TT
State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death 2. Date of Death 10/18/2008 Month Day Year 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** silverstein anche 2:60 PM 10 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Ballimere Levindale hospital Baltimore geriatric If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days 1 □ M 2 🛚 F 167-30-9802 Yrs. MD 94 10/26/1913 Director Usual Residence of Decedent with the Maryland 10a. State 10c. City. Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director BALTIMORE MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2528 WILLOW GLEN DRIVE 21209 USA Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 □ Yes 2 No WHITE Specify: ģ Specify: 3 Nidowed 4 Divorced al Hygiene.

other than "natura
vent, the Medical E Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygienn Important: If item 27 is marked other than any Injury or other traumatic event, the ones. OWNER RETAIL SHOES 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be NATHAN **ABRAMSON** ANNA KLAWANSKY 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ANN COHEN / DAUGHTER 2528 WILLOW GLEN DR., BALTIMORE, MD 20b. Place of Disposition (Name of KIGGE PLACE) MEMORIAL PARK 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 ARemoval from State 10/20/2008 PHILADELPHIA, PA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? Month Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown 9 ☐ Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed certificate 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b, Time of 28d. Describe how injury occurred 28c. Injury at Work? Medical Certification: 5 Pending investigation Injury Natural within 24 hours after deau...

To the Funeral Director; f M 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 10-18-2008 Sm, nD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sein, m.D Belvedere Avenue, Ealtimire, MD 21215 2434 herd 2. Registrar's Signature 31. Date filed (Month, Day, Year) State OCT 22 2008 Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** :00 PM DA SIMMOND 10 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner PERRING BACTIMORE IS Under 24 Hrs. 8. Date of Birth (Month, Day, Year) GENESIS BALTIMORE 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 💢 Yrs 88 Director 03/28/1920 220-14-4713 MD Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or Items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MD Baltimore Parkville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1801 Wentworth Rd 21234 USA filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ .3 Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Drug Store Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Cashier permit. Pages 1 and 2 should be filed be partment of Health and Mental Hygin Important: If Item 27 Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Raffael Colangelo Liberta Schiavone 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ralph J. Farano/Nephew 4225 Long Green Rd. Hydes, MD 21082 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State injury 4 ☐ Donation 5 ☐ Other (Specify) 2008 Beltsville, Maryland Chesapeake Crematory Inc. 21. Signature of Funeral Service Licensee MOLY43 22. Name and Address of Facility Rel Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, Maryland 21286-23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Clisens Physician disease or condition resulting in death) rebral /Medical Due to (or as a consequence of): Examiner tailure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner the death certificate be executed far. that initiated events resulting in death) Last and P.O. Box 68760,4 Due to (or as a consequence of) attending physician Physician/Medical the as IF FEMALE use 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy for in the past 12 months? Month 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a ☐ Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed2 this certificate 1□ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA 4☑ Nursing Home 5☐ Residence 6 ☐ Other (Specify) 1 🔲 Inpatient P funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After (Month, Day Year) Injury 1 Matural 5 Pending investigation 1 ☐ Yes 2 PTÑo death. within 24 hours after death To the Funeral Director: 2 Accident in by the 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6 6095 MARSHLEE DR. #200 ELKRIDG & 21075 CRNP 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 2 2 Registrar

DHMH 17 Rev 1/2001

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		State of Maryland / Department of Health and Mental  Certificate of Death	Reg. No. 2008 33656	
Physici /Medi		Mont Sonor		
Examir	er	GOOD SAWARITAN HOSPITAL Baltimore	4c. County of Death	
Funeral Director		5. Social Security Number  162-36-7689  G. Sex  162   7. Age (In yrs. last birthday)   If Under 1 Year   If Under 24 Hrs.   8. Date   Months   Days   Hours   Min.   Months   Days   Min.   Months   Months   Min.   Months   Min.   Months   Months   Min.   Months   Months   Min.   Months   Months   Min.   Months   Mon	of Birth (2007) 1945 9. Birthplace (State or Foreign Country)	
Maryland a-f show ified at	ctor	10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits 1 □ Yes ♣♣No	
with the 3a or 28 t be not	I Director		10g. Citizen of What Country?  USA	
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. they than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notified at	by Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces? 12. Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 13. Was Decedent of Hispanic Origin? (Specify Yes, specify Cuban, Mexican, Puerto Rican, etc.) 15. Was Decedent of Hispanic Origin? (Specify Yes, specify Cuban, Mexican, Puerto Rican, etc.) 15. Was Decedent of Hispanic Origin? (Specify Yes, specify Cuban, Mexican, Puerto Rican, etc.) 15. Was Decedent of Hispanic Origin? (Specify Yes, specify Cuban, Mexican, Puerto Rican, etc.)		
Maryland 21215-0036 and 2 should be filed within 72 hours after alth and Mental Hygiene. 27 is marked other than "natural", or is a traumatic event, the Medical Examiration of the marked other than "natural".	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  4  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Electrical Technician	16b. Kind of Business/Industry Service Industry	
Maryland 2 Maryland 2 to 2 should be filed lith and Mental Hyg 27 is marked other traumatic event, 1	To Be Co	17. Father's Name (First, Middle, Last) Frank Sener  18. Mother's Name (First, Middle, Last) Vivian		
re, Mar is 1 and 2 sh of Health and item 27 is m other traum		19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rural Route Notes)  212 Rothwell Dr. Luthervil		
es 1 g of He fitem		20a. Method of Disposition  1  Burial 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Chesapeake Crematory Inc. 2008		
Baltimo permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licensee  10.1443  22. Name and Address of Facility  Cremation and Funeral Alt		
Syeo, W. Medical Examiner per executed the burial-transit the burial-transit	dical Examiner	ical	d	URE Interval Between Onset and Death
, P.O. Box 687 that the death certificate ed by the attending phys detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)	23d. Date of delivery  Month Day Year	
cords, P.O. Bc w requires that the death s been signed by the atter should be detached for u	þ	Practility of the significant conditions continuously to death but not resulting in the underlying cause given in Part 1.	Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Unknown	
Rec he law e has b	Completed	24a.  1		
on or Vita ding Physician: After this certifica funeral director,	To Be	1 Yes 2 No Pospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5	nnly one)  Residence 6 □Other (Specify)	
☐ ng ng linei	Certification:	27. Manner of Death 1	8d. Describe how injury occurred  8f. Location (Street and Number or Rural Route Number, City or Town, State)	
Divisio  To the Hospital or Attendi within 24 hours after death.  To the Funeral Director: A completely filled in by the fu	Medical Ce	29a. Certifier  (Check only one)  29a. Certifier  (Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the and manner stated.	o the cause(s) and manner as stated. time, date and place, and due to the cause(s)	
To the within 3 To the comple	Mec	29b. Signature and title of certifier  29c. License number  D061789	29d. Date signed (Month, Day, Year)	
241	-	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  LORFAINE OF ORI AWAH, UND, 56 07 LOCH RAVEN BLVD	BALTIMORE, MD 21230	
Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature	,- Janoy.	

DHMH 17 Rev 1/2001

Amend #15 perFh G884 10/22/08 TT Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year 35 CLM 200 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3514 Bultmore Ituncare (it If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Hours 179-26 Director 2 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ite Medical Evantical must be notified at any injury or other traumatic event, Ite Medical Evantical must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Nes 2 No Director timere 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 35 Id Completed by Funeral 12. Was Decedent Ever in U.S Armed Forces? 1 \( \text{Yes} \) 2 \( \text{No} \) Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Neyer Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐Yes 2 ☐No Specify: White 3 ₩idowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 5+ College (1-4or 5+) TEACHER **EDUCATION** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WILLIAM KATZ FAYE GERSHENSON ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JON SCHREIBER / SON 12305 CLEGHORN ROAD, COCKEYSVILLE, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State BALTIMORE HEBREW 10/20/2008 REISTERSTOWN, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cancer **Physician** disease or condition resulting in death) Ci (Cinonths /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infine diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) To the Hospital or Attending Physician: The law requires that the de within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completely filled in by the funeral director, page 2 should be detached it 9 Hlnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □ No 24a. Was an autopsy performed? 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 | Yes 2 | No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21202 St

Registrar

State

31. Date filed (Month, Day, Year)

22

2008

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** IAM TIPTON  $\bigcirc \&$ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MARYUAND MED OF BAUTIMORE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 2 F **Director** 03/09/1957 216-72-5417 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show must be notified at 1 Yes 2 No Director MD Harford Edgewood 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 23a or death with Funeral 21040 604 Red Oak Rd 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 14. Race - American Indian. 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after I Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Experiment 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Heating & Air Conditic Elementary/Secondary (0-12) College (1-4or 5+) Mechanic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ William Henry Tipton May Christina Becker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosalind Shebora/Sister 147 S. East Ave Baltimore, MD 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Oct 17 4 Donation 5 Dother (Specify) Beltsville, Maryland 2008 Chesapeake Crematory Inc 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation and Funeral Alternatives de 8717 Green Pastures Drive Baltimore, Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) COMPLECATIONS **Physician** 42 DAYS /Medical Due to (or as a consequence of): Examiner ND STAGE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician; The law requires that the death certificate be executed ALCOHOLISM Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.0. signed by the a I □Yes 2 □ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown cate has been si page 2 should t 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □ □Vo autopsy perform certificate 1 ☐ Yes 2 X No 25. Was case referred to medical examiner?
1 Yes 2 □ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier t Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number NPI NUMBER 29d. Date signed (Month, Day, Year) 1871753905 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

21201

GREENE ST BACTEMORE

Registrar

State

B

83

32. Registrar's Signature

NASRALLAH

31. Date filed (Month, Day, Year)

08-0790	5
Eunice 7	Taylor

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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unice rayior		For State Of Maryland / Department of He  Certificate of De		Reg. No.	
Physician	_	Decedent's Name (First, Middle,Last)		Date of Death     Month Day	3. Time of Death
Medical Examine	er	Eunice laylor	30 1	October 20, 2008	2126 nrs
	. 4	,	ty, Town, or Location of Death	4c. Co	ounty of Death
E-many			Jnder 1 Year I If Under 24Hrs.	8. Date of Birth (MM/DD/	YYYY) 9. Birthplace (State or
Funeral Director	2	242-76-2732 1 M 2 F 69 Yrs. Mc	onths Days Hours Min.	Feb. 16, 19	39 Foreign Country) N. Carolina
any	-	Isual Residence of Decedent  0a. State 10b. County 10c. City, Town or Location		F 951	10d. Inside City Limits
ž .	5 /	Maryland N/A	Battimore		1 Yes 2 No
the Miffied	<u> </u>	0e. Street and Number 3115 Mary Ave.	Zip Code 2/2/4	10g. Citizen	of What County?
er death with 1	Lera	Never Married 2 Married Armed Forces? If Yes, sp	cedent of Hispanic Origin? (Sp becify Cuban, Mexican, Puerto		Race - American Indian, Black, White, etc
nore, MD 21215-0036  ages 1 and 2 should be filed within 72 hours after death with of Feathand Mental Hygiene 11. If field 27 is marked other than "matural", or items other traumatic event, the Medical Examiner must be To Do Completed by Europr	بار 1	Widowed 4 Divorced If Yes, Give Yeer 1 Yes	2 No specify:		ecify: Black d of Business/Industry
2 hours "nature	g	Elementary/Secondary (0-12) College (1-4 or 5+)	sual Occupation (Give kind of v working life. DD NOT use reti	red)	as Hopkins
vithin 7.	Completed	H	ousekeeper		university
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than re event, the Medica	2 Pe	7. Father's Name (First, Middle, Last) Theodore Riddick	18. Mother's Name	(First, Middle, Maiden Sui	rname) /
2121 should be fil and Mental F is marked atic event,		92. Informant's Name/Relationship (Type, Print)  19b. Mailing Add  Victor Taylor - Lusband   3115			or Town, State, Zip Code)
ore, MD ses I and 2 show of Health and If item 27 is ther traumatin	- 1	0a. Method of Disposition 20b. Place of Disposition		Date 20c. Loc	cation - City or Town, State
Baltimore, permit. Pages I ar Department of Hes importants. If ite injury or other ir		4 Donation 5 Other Specify: Mt. Carme	Centery 10	128/08 Bal	timore, Maryland
Baltimo permit., Pag Department Important:		Jevintare 35B	and Address of Ficility  Frederick	Ker Fundial	re, Marshard 21229
Physician /Medical	1	23a. Part I. Enter the disease, or compilications that caused the death. Do not enter the months failure. List only one cause on each line.	ode of dying, such as cardiac o	or respiratory arrest, shock,	, or heart Approximate Interval Between Onset and Death
xaminer		Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	1 14		
		or condition resulting in death)  Due to (or as a consequence of):  Atherosclerotic cardio b. This ical altercation	vascular disea	se associate	ed with
		if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated		71	
Nsit ed		(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
'60, cate be executed physician and he burial - transit	Medical	X UNPENDED AMENDED PI line a-b, 27,	28a-f, perME G	885 11/13/08	3 TT
760, ficate b g physic s the bur		F FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de	eath 3 Ectopic pregna		Date of delivery Ionth Day Year
Division of Vital Records, P.O. Box 68760, ra for Attending Physician: The law requires that the death certificate be reafter death.  The Thirector Affect this certificate has been signed by the attending physiciled in by the funeral director, page 2 should be detached for use as the burilled in by the funeral director, page 2.	Physician/	past 12 months?  4 Pregnant at time of death 5 Other	(Specify)		
. Bo he dea y the a	ڇَٰ	Part II. Other significant conditions contributing to death but not resulting in the under	lving cause given in Part I	23e. Did tobacco us	e contribute to the cause of death?
P.O ss that i	à	art in Other Significant Conditions Continuing to Court Dut Not 1000 along in the Cines	lying dadde groot in the in the	1 Yes 2 1	No 3 Probably 4 🗸 Unknown
rds, require been si rould b	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
COI te law te has l	립			performed?	death?
II. The Triffica tor, pa	ဒ္ဓါ-	25. Was case referred to medical	26.Place of Death (Check		
Vita hysicis I direc	o Re	examiner?  1 V Yes 2 No  Hospital: 1 Inpatient 2 V ER/Outpatient 3		ng Home 5 Residenc	
Ing Pl	=	27. Manner of Death 28a. Date of Injury (Month, Day, Year)  28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury	
Sion Vitendi death. ector:	<u>ğ</u>	Pending Investigation 28e. Place of Injury - At home, farm, street, fa		subject was	
Division ital or a real Direction Illed in the control of the cont	Certification:	Suicide 6 Could not be determined (Specify) residence	ctory, office building, etc.	or Town, State) 3 Baltimore.	d Number or Rural Route Number, City 115 Mary AVe MD
	Medical C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred a cone) 2 Medical Examiner: On the basis of examination and/or investigation,	at the time, date and place, and in my opinion, death occurred	d due to the cause(s) and at the time, date and place	manner as stated. e, and due to the cause(s)
To To con	Se -	and manner stated.  29b. Signature and title of certifier	29c. License number		ate signed (Month, Day, Year)
the state of the s		Lis as, not	O.C.M.E.	Octob	ber 21, 2008
10/18	+	30. Name and address of person who completed cause of death (Item 23a)	Dellineana MD 04004	1	
\			Baltimore, MD 21201		
Sta Registr	re ar	31. Date filed (Moath, Day, Year) 008 32. Registrar's Signature			

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** WILSON EDWARD DOUGLAS 7.45 AM OCT 8 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Yoward Noward nha If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Months Days Director 220-20-4684 MD May 6 1926 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show Department of Health and Mental Hygiene. In proceeding them 23s or 28s-f show important: If Item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examiner must be notified at once. MD Director Carroll Eldersburg 1 ☐ Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with 2013- 3D Rudy Serra Drive 21784 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1944 1 Tyes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: white þ - 1946 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Dept. of Defense technical illustrator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Edward S. Wilson Jessie E. Thompson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2013 - 3D Rudy Serra Dr., Eldersburg, MD 21784 Eleanor P. Wilson (spouse) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10-22-08 Clarksville, MD St. Louis Cemeterv 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Haight Funeral Home & Chapel ▶ Parge Haight Herbert Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CONGESTIVE HEART FAILURE Physician FEW DAYS disease or condition resulting in death) /Medical Examiner ISCHEMIC Due to (or as a consequence of): FEW MONTH CARDIO MYOPA THY if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Hospital or Attending Physician: The law requires that the death certificate be execut-Due to (or as a consequence of): FEW YEARS ARTERY DISEASE that initiated events physician and resulting in death) Last Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ END STAGE RENAL DISEASE. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed MALNUTRITION 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 XNatural 5 Pending investigation Iniury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier 29d. Date signed (Month, Day, Year)

OCT 18,20,8

29c. License number 29b. Signature and title of certifier MD D0062634 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10802 HICKORY RIDGE RD COLUMBIA MD 21044 MATEEN AWAN 31. Date filed (Month, Day, Year) egistrar's Signature State 2008 Sal April ... Registrar DHMH 17 Rev 1/2001 **ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 3366 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JOSEPH C. WEIH. SR. .<sup>ay</sup> 2008 3:10 A M October 20 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Peartree Assisted Living Pasadena Anne Arundel 5. Social Security Number 8. Date of Birth 6. Sex 7. Age (In vrs. last birthday If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Hours Min. Months 217-14-6478 1 **X** M 2 □ F Davs 85 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Maryland Anne Arundel Glen Burnie 1 □Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13 Greenwood Avenue 21061 USA 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 Never Married 2 Married 1 XIYes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Yes 2 🛣 No Specify 3 Nidowed 4 Divorced WW 2 White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Balitmore City Police Officer 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Weih Helen Sickler 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda A. Newcomb (Daughter) 8007 Solley Rd., Glen Burnie, Md. 21060 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1K Burial 2 ☐ Cremation 3 ☐ Removal from State Md. Veterans Cemetery 10/23/08 Crownsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Kevin E Ecker Name and Address of Facility McCully—Polyniak Funeral Home, P.A. 3204 Mountain Rd., Pasadena, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Do Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) Due to (oi As a cons abele Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Due to (or as a consequence of) IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2 ☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ New 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 □ Yes 2 No 2 ( A 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Hospital: 1 ☐ Yes 2 7 N 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 60 Other (Specify) HS (1) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred

**Physician** /Medical Examiner The law requires that the death certificate be executed

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or a may injury or other traumatic event, the Medical Evan in a must be a gang.

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

or Attending Physician:

Director

Funeral

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Completed

Be

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Examine physician and the burial-tran Physician/Medical as attending for use as nse signed by the a certificate has been s rector, page 2 should Completed director, Be Certification: To

After this funeral

To the Hospital or Attendin-within 24 hours after death. To the Funeral Director: Af completely filled in by the fu

0

State

29b. Signature and title

5 Pending investigation

6 ☐ Could not be

determined

29c. License numbe

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 ☐ Yes 2 ☐ No

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

and address of person who completed cause of death (Item 23a) (Type, Print) 60

and manner stated.

Registrar's Sig

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Medical

1 Natural

2 Accident 3 ☐ Suicide

4 ☐ Homicide

(Check only

29a. Certifier

Registra DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2008 JOHN HENRY WAGNER 4:26A <sup>™</sup> OCT. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE TOWSON GILCHRIST CENTER Trunder 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours Min. Sept. 20, 1919 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **X**XM 2□ F Maryland 216-07-6110 Yrs 89 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Baltimore County 1 ☐ Yes 2XXNo Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21234 3002 Lavender Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊡Yes 2 X∭No IfYes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married White 1 ∐ Yes 2**X**ONo Specify 3 ™ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Display Center 12 yrs. Cabinet Maker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Amelia C. Hecker Frederick W. Wagner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ms. Marlene J. Wagner (Daughter) 3002 Lavender Avenue Baltimore, Md. 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ★ Burial 2 Cremation 3 Removal from State Parkwood Cemetery 10~20~2008 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee <sup>22.</sup> Name and Address of Facility Home Zassahn 7401 <u>Belair Rd. Baltimore, Md. 2123</u>6 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death nmediate Cause (Final YEARS disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, and the list of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy Day Year 5 Other (specify) 1 TYes 2 □ No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? STROKE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 2 Unknown CANCER 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No PROSTATE 24a. Was an autopsy performe 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 MOther (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 □Yes 2 □ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

The law requires that the death certificate be executed Box 68760, P.O. of Vital Records, Physician: Division

physician and the burial-transit attending pl ned by the a signed by t page 2 should After this certificate has To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

**Physician** 

/Medical

Examiner

Funeral

**Director** 

show

Director

Funeral

2

Completed

ed other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at

death

filed within 72 hours after

permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "n, any injury or other traumatic event, the Mental once.

Physician

/Medical

Examiner

Exami

Physician/Medical

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Completed

Be

Certification: To

Medical

29a. Certifier

3altimore, Maryland 21215-0036

State

Registrar

29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

264395

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

OCTOBER 17, 2008

DANIEUE DOBERMAN, MO

and manner stated.

6565 N CHARLES ST. SUITE 209 BALTIMORE, MD 21204

32. Registrar's Signature

#31, per DVR g884 10/22/08 TT Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend State of Maryland / Department of Health and Mental Hygiene 33663 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** wandersman Month Year sid 1130 PM october /Medical 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death Examiner 4c. County of Death who Hopkins Baysiew are Cete Baltra If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months | Days | Hours | Min. 0 / 4/90th Day, Year | 0 / 1924 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2□ F Months 070-26-8557 **POLAND** Director Usual Residence of Decedent r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD MONTGOMERY ROCKVILLE 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be in 6105 MONTROSE ROAD 20852 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 【No Specify. Specify: WHITE þ 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien Important: If item 27 is marked other the any Injury or other tressure. PLASTICS MACHINE OPERATOR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be SHAYA WANDERSMAN ZLATA ပ UNKNOWN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SUZANNE WANDERSMAN / DAUGHTER 25 HOLLYBERRY COURT ROCKVILLE, MD 20852 3altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation Removal from State 4 □ Donation 5 □ Other (Specify) BRITTON ROAD CEMETERY 10/19/2008 GREECE, NEW YORK 21. Signature of Funeral Service Lice 22. Name and Address of Facility SOL LEVINSON & BR 8900 REISTERSTOWN ROAD PIKESVILL 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** irchurst disease or condition resulting in death) :40 /Medical Due to (or as a sequence of): Examiner a cometanical Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine be executed sitaldad and burial-trar Due to (or as a consequence of) physician Physician/Medical the attending IF FEMALE: for use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death Day Year 5 Other (specify) P.O. ed by the a detached f 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 autopsy perform certificate Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA P funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of After t Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D04383 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOPKINS BAYVIEW 2002 CIRCLE reenought 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month PM **Physician** 2008 oseDV /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A **Baltimore City** The Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Days (Month Day, Year) 25 **Funeral** 1 ▼ M 2 □ F 83 POLAND 219-30-3163 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director BALTIMORE STEVENSON MD 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number Items 23a 21153 USA 1514 NEAR THICKET LANE Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married WHITE 1 ☐ Yes 2 No ò Maryland 21215-0036 Specify þ 3 Widowed 4 Divorced "natural". Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) than HOME BUILDING BUILDER marked other 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be 2 should be finance and Mental H HARRY WILDER MALKA UNKNOWN Pages 1 and 2 should မှ Injury or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health and tem 27 is I ROSE WILDER / WIFE 1514 NEAR THICKET LANE STEVENSON, MD 21153 Department of Healt Important: If Item 2 any Injury or other once. Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition to ARLINGTON 1 XBuriai 2 Cremation 3 Removal from State 10/19/2008 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD PIKESVILLE. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final emi Physician . Wee disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine The law requires that the death certificate be executed physician and as the burial-trans resulting in death) Last Physician/Medical use as attending p IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Month Day in the past 12 months? Pregnant at time of death 5 Other (specify) been signed by the a should be detached 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate has No 1 Yes Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one funeral director, Be Hospital Other: 1 Inpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) မ 1 Tes 2 ER/Outpatient 3 DOA After this Date of Injury (Month, Day Year) 27. Manner of De 28c. Injury at Work? 28a. 28b. Time of 28d. Describe how injury occurred Certification: Injury 5 Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined

Division of Vital Records, P.O. Box 68760, death. filled in by the

To the Hospital or Attending Physician: within 24 hours after deatl

To the Funeral Director:
completely filled in by the

are and title of certified

4 🗌 Homicide

(check only

29a. Certifier

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number,

ho completed cause of death (Item 23a) (Type, Prin Med

600 North Wolfe St, Baltimore, MD, 21287

City or Town, State)

State Registrar

Medical

31. Date filed (Month; Dey, Year) 32. Registrar's Signature

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 33665 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death **Physician** Day Year /Medical Reverend Leon K1emens Warczynski October 19 2008 9:15 A 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Stella Maris Timonium Baltimore 5. Social Security Number 6 Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Aug. 3 191 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Months Days Hours Min **№** М 2 Б Maryland Director 220-44-6272 Aug. Usual Residence of Decedent Show 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show the Wedical Evantimer must be notified at Director X□Yes 2□No Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21214-3318 U.S.A. 3316 Beverly Road Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc. 1 Never Married 2 ☐ Married 21215-0036 1 ☐ Yes 2 Z No Specify: þ 3 Widowed 4 Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Archdiocese of College (1-4or 5+) Elementary/Secondary (0-12) Roman Catholic Priest Baltimore permit. Pages 1 and 2 should be filed in Department of Health and Mental Hygin Important: If item 27 is marked other any injury or other traumatic event, III Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henery 2 Warczynski Anna Beksinski 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maryland 21214-3318 <u>Leona Andryszak ( Neice )</u> 3616 Beverly Road Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2008 Baltimore, Maryland Stanislaus Cemetery 22. Name and Address of Facility. W. Dabrowski/Chojnacki Funeral Homes P.A. 21. Signature of Funeral Service 1ask 1005 Dundalk Ave. Baltimore, Maryland 21224 23a. Part 1. Enter the disease, or complications the shock, or heart failure. List only one cause of caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. Approximate Interval Between Immediate Cause (Final Onset and Death **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of executed burial-tran Due to (or as a consequence of): Box 68760, attending physician The law requires that the death certificate be Physician/Medical as IF FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death for 1 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) P.O. detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, \$ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? has 24a. Was an autopsy perform certificate Vital 2 No 2 □No 1 □ Yes 1 ☐ Yes Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To oţ this 28a. Date of Injury (Month, Day, Year) Hospital or Attending P 24 hours after death. Funeral Director: After t 27. Manner of Death 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending investigation 2 Accident 1 ☐ Yes 2 🗆 No filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide e Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only one) within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 032882 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROBERT MOSS, M.D. 2300 DULANEY VALLEY ROAD TIMONIUM MD21093 31. Date filed (Month, Day, Year) 32. Hegistrar's Signature State Book . OCT 22 2008 Registrar

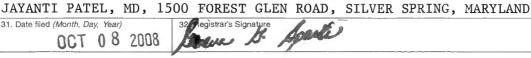
A.M.

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State Registrar

31. Date filed (Month, Day, Year) 08 2008



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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Physician Richard Allen 10:45 PM 2008 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) County of Death Examiner Salisburu Wicomico Salisbury Rehaba N
5. Social Security Number 6. Sex ursing If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**⊠** M 2□ F 213-22-6001 Director 80 3/19/1928 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 XYes 2 No Director Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Canal Woods II 21804 USA Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 XYes 2 No 'natural', or If Yes, Give Year or Dates: Navy 1 ☐ Yes 2 No Specify. Specify: þ white 3 ☐ Widowed 4 ☐ Divorced Hi Chand Baltimore, Maryland 21215-00 Completed event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 W.F. Allen Co. owner Pages 1 and 2 should be filed to nent of Health and Mental Hygic int: if item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Albert G.Allen Marie Walls ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau A. Gillis Allen II/son PO Box 990, Salisbury, MD 21803 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 10/7/08 Salisbury Crematory 4 □ Donation 5 □ Other (Specify) Salisbury, MD of Funeral Service Cens P. Name and Address of Facility
HOLLOWAY Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a Pa ri. Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, slock, or heart failure. List only one cause of the death. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) 6 4021-/Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last physician and s the burial-tran Due to (or as a consequence of) Box 68760, Physician/Medical as attending p IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No Ö signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ģ 2 → Ho 3 □ Probably 4 □ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autopsy performed certificate 1∐ Yes 2 4No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐ No P 1 Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After th. 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year)

State

Registrar

31. Date filed (Month, Day, Year) 0CT 0 7 2008

William H. Robins

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

m.D. 200 Civic
32. Redistrar's Signature

Salisbur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Nicholas L. Biocco October 12, 2008 /Medical 10:35A 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 105 Fox Run Grasonville Queen Annes 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) **1** M 2□ F Months Days 151-22-9558 Director 78 December 13, 1929 New Jersey Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City. Town or Location in than "natural", or items 23a or 28a-f show 10d. Inside City Limits Director Maryland 1X Yes 2 □ No Queen Annes Grasonville 10e. Street and Number 10g. Citizen of What Country? 105 Fox Run 21638 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☑No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 🌠 No ģ Specify: 3 Widowed 4 Divorced Specify: White Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) should be filed within and Mental Hygiene. s marked other than. Elementary/Secondary (0-12) College (1-4or 5+) Engineer of Health and Mental Hygie fitem 27 is marked other t r other traumatic event, the Inspection Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should Paul Peter Biocco Meadeline Consorto 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau
once. Deborah M. Holden/Daughter 105 Fox Run, Grasonville, Maryland 21638 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 11 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ST. Joseph Cemetery10-16-08 Chewslanding, NewJerse 22. Name and Address of Facility Marzullo Funeral Chapel, P. A 21. Signature of Funeral Service License mulail 6009 Harford Road, Baltimore, Maryland21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician cardiomyopath Ischemic disease or condition resulting in death) 16 years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a nunsequence on attending physician and for use as the burial-transit certificate be exect Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2☐No 0 ģ σ. signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Records, 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? as e 2 s 24a. Was an autopsy performed of Vital 1 □ Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? After 28d. Describe how injury occurred Division or Attending 1 Natural 2 Accident 5 Pending investigation nours after death.

neral Director: Af

y filled in by the fur 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 hor To the Fune completely fi (Check only and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) person who completed cause of death (Item 23a) (Type, Print) 30. Name and address of 115 Sallith Drive, Suite E Stevensville, MD 21666 Konick MID kiniel 31. Date filed (Month, Day, Year) 82/Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year 8:45AM ELVIN BERTRAM BUNYAN OCTOBER, 02 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death OLNEY MONTGOMERY MONTGOMERY GENERAL If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number Days Hours Months 1**X**M 2□ F 23 1929 BEQUIA NONE Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐Yes 2 No OLNEY MD MONIGOMERY 10g. Citizen of What Country? ST. VINCENT AND THE 10f. Zip Code 10e. Street and Number GRENADINES 20832 15 SHADOWRIDGE 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🗷 No Specify. Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE SAILOR 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) LESTELLE QUASHIE BERTRAM BUNYAN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) SPOUSE 20832 OLNEY 15 SHADOWRIDGE NORMA GOODING BUNYAN 20c. Location - City or Town, State
PORT ELIZABETH Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 X Removal from State OCT. 19 2008 4 □ Donation 5 □ Other (Specify) ELIZABETH BEQUIA ALSTON 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MSBEAN 5 20785 COUNTRY WOOD CT. LANDOVER 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Organ Due to (or as a consequence of): Due to (or as a consequence of) aeni ( Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 Pregnant at time of death 5 ☐ Other (specify) 9 T Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 25. Was case referred to medical 2 1 No 2100 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred

**Physician** /Medical Examiner Examiner

physician and the burial-transit

attending pl for use as t

cate has been signed by the page 2 should be detached

To the Hospital or Attending Physlcian: The law within 24 hours after death.

To the Funeral Director: After this certificate has I completely filled in by the funeral director, page 2 s

Physician/Medical

ģ

Be Completed

Certification: To

Medical

death certificate be executed

Box 68760,

P.O.

Division of Vital Records,

Department of Health a Important: If Item 27 is any Injury or other trai once.

Physician

/Medical

Examiner

**Funeral** 

Director

28a-f show

Funeral Director

Completed by

Be

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7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, "ny Mydical Exemiting a

and Mental Hygiene.

Baltimore. Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE: 23b. Was decedent pregnant

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

27. Manner of Death Natural 2 Accident

3 ☐ Suicide

4 T Homicide

5 ☐ Pending investigation 6 ☐ Could not be

determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 □Yes 2 □No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifie (Check only one)

PADMAJA

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D 0 0 68 0 2 6

29d. Date signed (Month, Day, Year) 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DRIVE 18101 PRINCE PHILIP OLNEY

State Registrar

31. Date filed (Month, Day, Year) 08 OCT 2008

BANDI



DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year 29 AM Rroc Month **Physician** ٤li 20 bet /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bayview Medical Campus Baltimore 5. Social Security Number Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 😿 F Director <u> 220-32-1756</u> 09-13-1935 Va Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State d other than "natural", or items 23a or 28a-f show event, the World Ever, it are in ust be notified at 1 Yes 2 No Director Md. Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 4358 Parkside Dr. 21206 Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 □Yes 2 No Specify: ģ Black 3. Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 10 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be innent of Health and Mental Alvin Johnson ျှ Hope Faith Charity Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health Important: If item 27 any injury or other troops 27 Etta Currie / Daughter 4358 Parkside Dr. Baltimore, Md. 21206 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Wesley Cem | 10-04-08 | Chester, Maryland 22. Name and Address of Facility Bennie Smith Funeral Home 21. Signature of Funeral Service Licensee 426 Dover Street, Easton, Maryland MAD 23a. Part 1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. cop End Immediate Cause (Final **Physician** 1+a disease or condition resulting in death) /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter triangling Cause (Disease or injury) Examiner Due to (or as a consequence of) law requires that the death certificate be executed burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No P.0. ed by the a 9 Unknown s been signed to should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform VH certificate 2 📭 1 ☐ Yes 2 ☐ No 1 ☐ Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Medical Certification: To this 28b. Time of Injury . Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After t 27. Manner of Death Hospital or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 24 hours after death Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 29a. Certifier 1💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) and manner stated. within 2. the

2

State Registrar 29b. Signature and title

2201

gleted cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

08-07463 John	Andrew Betch Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
UNK UNK	State of Maryland / Department of Health and Mental Hyglene
	1- For State Certificate of Death Reg. No.  Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death 3. Time of Death
Physician/ Medical Examiner	Month Day Year
Jan &	4a. Facility Name (if not institution, give street and number)  4b. City/Town, or Location of Death  4c. County of Death
Eurosol	2801 Hawkins Point Road  Baltimore  5. Social Security Number   6. Sex   7. Age (In yrs. last birthday)   If Under 1 Year   If Under 24Hrs.   8. Date of Birth(MW/DD/YYYY)   9. Birthplace (State or
Funeral Director	214-88-3237 IXM 2 F 34 Yrs. Months Days Hours Min. Sept. 201974 Foreign Country Maryland
	Usual Residence of Decedent
ow any	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No
Aaryland 28a-f show at at once, ector	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
th the Maryland th the Maryland anotified at once,	7957 Sunshine Court Aptil 21061 USA
r death with	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
er death w , or items or must be Funer	Armed Forces?    1   Yes   2   X   No     3   Wildowed   4   Divorced   If Yes, Give Year   1   Yes   2   X   No   specify:   Specify:
ours aft	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
5-0036 led within 72 hours after tygiene. other than "natural", the Medic J Examiner Completed by	Elementary/Secondary (0-12) College (1-4 or 5+)
215-0036 be filed within 7 mtal Hygiene. rked other than ent, the Medical	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)
215 be file ontal Hy rrked o rrked o	John Betch, SR. Terry Gilkerson
Baltimore, MD 21215-0036 bernit. Pages I and 2 should be filed within 72 hours after death with the Maryland bepartment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she nijury or other traumatic event, the Medie A Examiner must be notified at once To Be Completed by Funeral Director	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Fural Route Number, City or Town, State, Zip Code)
ore, MD st. and 2 sho of Health and fritem 27 is her traumati	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State
altimore, rmit. Pages I an epartment of Hea pportant: If iten inry or other tr.	1 Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify:  Wid Shore Cremation 10/8/08 Cambridge, MD;
Baltimc permit. Page Department of Important: injury or ott	21. Signature of Funeral Service Licensee  22. Name and Address of Facility  Henry Fune Rol Home, P. A.  Henry Fune Rol Home, P. A.
	232 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or part Approximate Interval
Physician /Medical	failure. List only one cause on each line.  Between Onset and Death
xaminer	Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):
0	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):
i i	Cause. Enter Underlying Cause (Disease or injury that initiated
uted Id ansit	events resulting in death) Last Due to (or as a consequence of):
, be exect cian an irial - tr irial - tr	UNPENDED AMENDED
Box 68760, e death certificate be the attending physic ef for use as the bur hysician/Mec	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year
X 68 th certi ttendin r use ar	past 12 months?    1   Live birth   2   Fetal death   3   Ectopic pregnancy   Month   Day   Fetal death   5   Other (Specify)     1
Vital Records, P.O. Box 68760, hysician: The law requires that the death certificate be executhis certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial - tr	Yes 2 No 9 Unknown g Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the rs after death.  **I Director: After this certificate has been signed by led in by the fumeral director, page 2 should be detach ertification: To Be Completed by P	1 Yes 2 ✓ No 3 Probably 4 Unknown
rds, requir been s should 1	24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of
Records, The law requires ficate has been sig	performed? death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No
tal Fician: Certific	25. Was case referred to medical 25. Place of Death (Check only one)
of Vir Physic Presentation	1 V Yes 2 No Impatient 2 Environment 5 Don 1 Training notice 5 Tra
Division or spital or Attending tours after death neral Director: Afte filled in by the fune Certification:	1 Natural 5 Pending Oct 2, 2008 1208 hrs 1 Yes 2 ✓ No A motor veicle fell on top the subject
or Atti or Atti filer de Directi in by 1	2 M Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State)
Dispital bours a rilled Cert	
Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be executifing the hours after death.  To the Fineral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transfer of the fine at the formal or transfer of the funeral director. To Be Completed by Physician/Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  (Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
To wit	
	O.C.M.E. October 3, 2008
	30. Name and address of person who completed cause of death (Item 23a)  Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
State	31. Date filed (Month, Day, Year) 32. Segistrar's Signature
Registra	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Day Physician Year Mer ee 2008 Oct /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Bay Cambrid Dorchester Nursing Center Social Security Number yrs. last birthday If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Director Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 ☑Yes 2 ☐ No Directo 10g. Citizen of What Country? 10e. Street and Number USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 DPYes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1□Yes 2☑No Baltimore, Maryland 21215-0036 "natural", or 3 Widowed 4 Divorced Black er than "natura", the Medical E 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) -armer item 27 is marked other other traumatic event, t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Brannock ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cambridge MD. 21613 Fliott Ave. Mary 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of Important: If its any Injury or o 1 Burial 2 □ Cremation 3 □ Removal from State Taylors Island Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Taylors Island, MD. 21. Signature of Funeral Service Licensee Henry Funeral Home, P. 510 Washington St. C 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician dementia /Medical Due to (or as a consequence of) Examiner 2th lero sclerosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed Exam attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day 5 Other (specify) I ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Medical Certification: To Be Completed by 2 X/No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy or Attending Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural
2 Accident 5 ☐ Pending investigation (Month, Day Year) Injury 1 ☐ Yes 2 ☐ No within 24 hours are death To the Funeral Director completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year)

Johnson Year)

atticia

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Cambridg MO 00 Bramble egistrar's Signatur

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Madeline Robbins Brower 2008 ctoher /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** DORCHESTER GENERAL HOSPITAL DORCHESTER CAMBRIDGE 5. Social Security Number If Under 1 Year If Under 24 Hrs Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Months 1 M 2 F Director 10, Maryland 217-14-8199 Feb. 1924 Usual Residence of Decedent 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits item 27 is merked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must by motified at 1 Yes 2 No Director MD Dorchester Cambridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 319 Shepherd Avenue 21613 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married If Yes Give 1 ☐ Yes 2x No Specify ģ Specify: white 3 ₩ Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. merked other than Elementary/Secondary (0-12) College (1-4or 5+) 8 homemaker own home Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be f nent of Health and Mental i ant: If item 27 is merked o ၉ Charles R. Robbins Alverta Shorter 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Keith H. Brower son 403 Forest Drive, Fruitland, MD 21826 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State Department of Important: If it eny injury or o 1 □ Burial 2 □ Cremation 3 □ Removal from State Dorchester Mem. Park : 10/10/08 Cambridge, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility 21. Signature o Funeral Servic Lensee Thomas Funeral Home P.A. lung 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of ach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** (14 resulting in death) /Medical Due to (or as a consequence of): Examiner (diom. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner (or as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) signed by the attending physician the detached for use as the buria P.O. Box 68760 Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectonic pregnancy Month Year Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 □Yes 2 □ No 9 Unknown 9 Hinknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 3 Probably 4 Unknown RUMON peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy ntectio certificate 210 1 ☐ Yes 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Impatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1) Natural 5 Pending 2 Accident 1 ☐ Yes 2 ☐ No investigation after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical completely (Check only one) within 2 29b. Signature and little of certifier 29d. Date signed (Month,)Day, Year) 30. Name and address of person who camplet d cause of death (Item 23a) (Type, Print) 100 Branble St NARZ 31. Date filed Month 32. Re strar's Signature

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State Registrar

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DHMH 17 Rev 1/2001

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BELLOSO, M.D.; 5302 CHINABERRY DR., SALISBURY, MD 21801

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#20b, perFH, G884, 10/22/08, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** =LS1 2.00 8 0 16 -08 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Citizens Care and Rehab. Frederick Frederick If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 11-12-1912 Birthplace (State or Foreign Country)
 MD 7. Age (In vrs. last birthday) **Funeral** 1 П м 2 № Т Б Days Hours Min 95 218-24-9710 Yrs Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County item 27 is marked other than "natural", or itams 23a or 28a-f show other traumatic evant, the Madical Examinar must be notified at 1 Yes 2 No Funeral Director Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 303 Barbara Street 21701 14. Race - American Indian, Black, White, etc. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No þ Specify: White 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed withi Department of Health and Mental Hygiene. Important: if item 27 ls marked other than Hood College House Keeping 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Martin Luther Stockman Julia Catherine Marsh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anna Mae Miller Niece 7212 Rainbow Lane Frederick , MD 21702 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 5 1 Burial 2 Cremation 3 Removal from State 10-20-2008 Mount Olivet Cem. Frederick, MD ` 4 ☐ Donation 5 ☐ Other (Specify) any injury 21. Signature of Funeral Service/Ligensee 22. Name and Address of Facility Keeney & Basford P.A. F.H. 106 East Church Street Frederick, MD 21701 110 M01176 23a. Part L Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stack, or heart failure. List only one cause on each line. ocardid Infanction rediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): the attending physician thet for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) detached 1 Yes 2 No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No been a Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy 2 🗆 No 2 No 1 Yes or Attending Physician: 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Uniursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3□ DOA this filled in by the funeral 27. Manner Death 28a. Date of Injury (Month, Day Year) After t 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 atural 5 Pending investigation Injury death. 1 🗌 Yes 2 🗌 No 2 Accident Director: 3 🗋 Suicide 6 □ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide the Hospital within 24 hours 1 🗹 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) 0 W ess of berso 30. Name and addr who completed cause of death (Item 23a) (Type, Print) MD-80

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

22

2008

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October 17, **Physician** 2008 ar 12:05 PMM Ruth Evelyn Crawford /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Frederick Citizens Care & Rehabilitation Center Frederick 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, July 5, 9. Birthplace (State or Foreign 1□ M 2□ F Months Days Hours Min. 98 219-34-5796 **Ohi**ó Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits Braddock Heights Director Maryland Frederick 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6827 Maryland Ave. 21714 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 □ Yes 🎀 No Specify. Specify: White þ ₩Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Health Care Registered Nurse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles H. Shull Cora Little ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6827 Maryland Ave., Braddock Heights, MD 21714 Mary Lynne Thomas, daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State Mount Olivet Cemetery Oct. 21, 2008 Frederick, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign tuly of Funded pervice Licent <sup>22.</sup> Name and Address of Facility Keeney and Basford PA Funeral Home MO0255 106 East Church St., Frederick, MD 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Infarction Myocardial disease or condition resulting in death) Hem Due to (or as consequence of): Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or a l consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 1 ☐ Yes 2 🔼 No 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an autopsy 2 No 1 □Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No

Box 68760 to the Hospital or Attending Physician: The law requires that the death certificate P.0. Division of Vital Records,

Examiner

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, It. Medical Evan, that is usal be notified at

**Physician** 

/Medical

Examiner

burial-tran

attending physician for use as the buria

been signed the should be determined to the second to the

has page 2

certificate

this funeral

within 24 hours after death

To the Funeral Director:
completely filled in by the

Be

Certification: To

Medical

Baltimore, Maryland 21215-0036

2 Accident 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) D43091 14-20-08

5 State

Registrar

Saco 31. Date filed (Month, Day, Year)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

801

Tou House Ave

Frederich MD 21701

nberly Nicole	Cai	otato of Maryland / Department of Health and Mental 11			0 2267
		Registrar Certificate of Death	Reg.	No. 200	
Physici edical Exami		1. Decedent's Name (First, Middle,Last)  Kimbert! Nicole Cain  4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death	Date of Death     Month D     October 12,	ay Year 2008	3. Time of Death 2331 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 5300 Block Route 40, Room 35 Perryville	·	4c. County of Death Cecil	D D
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs Months Days Hours Min	-	MM/DD/YYYY) 9. Birtl Foreign	
Director		214-11-9747 1 M 2X F 22 Yrs. World Bays Hours Will Usual Residence of Decedent	01/04/1		ntry) MD
any		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
tand f show	tor	MD Haford Havre de Grace			1 Yes 2 No
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland sent of Heath and Mortal Hygiene, not: If then 21 is marked other than "natural", or items 23a or 28a-f show any rother traumatic event, the Medical Examiner, must be notified at once.	Funeral Director	10e. Street and Number 10f. Zip Code	10g.	Citizen of What Coun	try?
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215-0036 be filed within 7 stal Hygiene. sked other than ent, the Medic	Be C		(First, Middle, Mai		
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MD and 2 sho salth and 2 sho sem 27 is		Leon M. Lust (Uncle) 112 Francis St. Hav. 20a. Method of Disposition (Name of cemetery,	re de Gra	ce Maryla Oc. Location - City or	nd 21078
Ore ges 1 a t of He : If it		1 Burial 2 X Cremation 3 Removal from State crematory or other place)		·	
Baltimore, permit. Pages I an Department of Hea Important: If itel	-	4 Donation 5 Other Specify: R.A. Ferris & Co Inc. 10 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ze	/20/2008	West Chest	er. PA
Dep Dep		Tara C. Zellman PERDVR 123 S. Washington  23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of	St. Hav	eral Home, ro do Grac	P.A.
Physician /Medical		failure. List only one cause on each line.	or respiratory arrest,	shock, or heart	Approximate Interval Between Onset and Death
'xaminer		Immediate Cause (Final disease or condition resulting in death)  a. Gunshot Wound to Head  Due to (or as a consequence of):			
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause			
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Box 68760, e death certificate be the attending physic ed for use as the burst	cian	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnant at time of death 5 Other (Specify)	ancy	Month D	ay Year
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ital Recition: The secrificate rector, page	a	25. Was case referred to medical examiner?  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other4 Nursin			
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Division of Vital Records, P.O. Box 68760, Ilopital or Attending Physician: The law requires that the death certificate be 24 hours after death. Funeral Director: After this certificate has been signed by the attending physicitely filled in by the funeral director, page 2 should be detached for use as the buriled by	Certification:	3 Suicide 6 Could not be determined	or Town, State		al Route Number, City
Hospital 24 hours Funeral stely fille		29a. Certifier (Check only) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and			
To the Hos within 24 h To the Fut completely	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a and manner stated.			
	2	29b. Signature and title of certifier  29c. License number  O.C.M.E.	i .	9d. Date signed <i>(Mor</i> October 13, 2008	
	}	30. Name and address of person who completed cause of death (Item 23a)			
8		Jack Titus MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21	1201		
St Regist	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature			

DHMH 17 Rev 1/2001

ORIGINAL

OCME

8

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 2008 **Physician** Robert Wilson Colbourne Ctober 0616 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HICOMICO 341564M REGIONAL If Under 1 Year | If Under 24 Mrs. Date of Birth (Month, Day, Young 11, . Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** , 1909 Months Days Hours Maryland 99 231-42-8398 Aug. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examiner most to notified at 1 ☐ Yes 2 X No Director Maryland | Dorchester Secretary 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21664 USA 3754 Sunnyside Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 ∐Yes 2 XI If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: ۾ Specify: White 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Wholesaler Seafood permit. Pages 1 and 2 should be filed i Department of Health and Mental Hygin Important; If item 27 is marked other i any Injury or other traumatic event, III 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Samuel Colbourne Effie May Craig 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) O. Box 124, Secretary, Maryland 21664 Betty Hollerman/Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) East New Market Cem. 10/5/2008 East New Market, MD 22. Name and Address of Facility
Zeller Funeral Home, P. O. Box 207
106 Main Street, East New Market, MD 21. Sign tun of Funeral Service Pay 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each, ine. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed and Due to (or as a consequence of): burial-Box 68760. attending physician Physician/Medical the as nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy P in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 ☐ Other (specify) P.O. the 9 Unknown signed by to be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performe certificate 2 🗆 No **Division of Vital** 1∐Yes 2XNo 1 □ Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1∐Yes 2MNo 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA this After thi funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending the Funeral Director: After Anietely filled in by the funeral investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier npletely (Check only one) the 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) ٥

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-8398

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State Registrar STEPHEN

31. Date filed (Month, Day, Year)

100E

strar's Signature

SALISBURY Md 21801

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MI)

KEIM

OCT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

		1 - State of Maryland / Department of Health and Certificate of Death	Reg.	2000 23480	
Physici /Medic		09 28 3508 10 10 11 11			
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Director		554-23-2753 1□ M 2▼ F 67 Yrs. Months Days Hours Min	03/19/19	41 Mexico	
Maryland t-f show	tor	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits  Delaware Sussex Bridgeville 1□Yes 2♥No			
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To hours after death with the Maryland 72 hours after death with the Maryland natural", or items 23a or 28a-f show death by marting at	by Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married  12. Married 13. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 No If Yes, Sive Year or Dates:  1. Was Decedent Hispanic Origin? If Yes, specify Cuban, Mexican, Pue If Yes, specify: Mo	(Specify Yes or No- erto Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: Mexican	
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Pages 1 and 2 nent of Health int: If item 27 I iry or other tra		20a. Method of Disposition  1		Location - City or Town, State  Bridgeville, DE	
permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Licensee	· · · · · · · · · · · · · · · · · · ·	202 Laws Street Inc. Bridgeville, DE 1	
after death.  In or Attending Physician: The law requires that the death certificate be executed after death.  Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the buriat-transit	edical Examiner	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):			
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	ρ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		to use contribute to the cause of death?  2 □ No 3 □ Probably 4 ▼ Unknown	
Th ate pag	Completed		24a. Was an - autopsy performed 1 □ Yes 2 <b>X</b>	24b. Were autopsy findings available prior to completion of cause of death?  No 1 □ Yes 2 □ No	
ysiciar s certii directo	To Be	examiner?	leath (Check only one)  J Home 5 ☐ Residence	6 Other (Specify)	
To the Hospital or Attending Physician; within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director, to	ation: T			Describe how injury occurred	
	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street City or Town, St	8f. Location (Street and Number or Rural Route Number, City or Town, State)	
e Hospi 24 hour e Funer letely fill	Medical	29a. Certifier  (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
	Me	29b. Signature and title of certifier  29c. License number  LG3HXXUM		Date signed (Month, Day, Year)	
284		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  ZAKIYA N LOCKHART 22 S. GREENE ST. B		MD 21201	
Sta Registr	_	31. Date filed (Month Pay, Year) 2008 32. Egistrar's Signature			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] [] S Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician FRANKLIN WALTER DRUMHELLER OCTOBER 2008 11:20AM M /Medical 4a. Facility Name (If not institution, give street and number) 4b City Town or Location of Death 4c. County of Death **Examiner** TALBOT TALBOT HOSPICE HOUSE EASTON 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1**X** M 2□ F Months Days Hours Min 65 Director 170-34-9205 NOV 29 1942 PA Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits Department of Health and Mental Hygiene. Important; or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. SHERWOOD 1 ☐ Yes 🌪 🗆 No Director TALBOT MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21665 USA 6677 REESES PRIDE ROAD Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ▼ Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: þ Specify: 3 Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DIRECTOR OF MANUFACTURING GARMENT 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ELIZABETH P. SMITH FRANKLIN L. DRUMHELLER 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BRENDA DRUMHELLER/SPOUSE 6677 REESES PRIDE ROAD, SHERWOOD, MD 21665 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) LEHIGHTON CEMETERY 10/10/2008 LEHIGHTON, PA 21. Signature of Funeral Service Licenses FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 31. Joseph 200 S. HARRISON ST., EASTON, MD 21601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause op each line. Approximate Interval Between Onset and Death Immediate Cause (Final ung cancer **Physician** disease or condition resulting in death) year 10 months /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed and Due to (or as a consequence of) physician a s the burialby Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 ☐ Unknown by signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1XYes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No certificate has t rector, page 2 s autopsy perform 2 No Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 1 Yes 2 No ဥ 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🗖 Other (Specify) this HOSPICE 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Iniury 1 ☐ Yes 2 ☐ No after death

Director: / 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. and title of certifier 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 1/2001

State

30. Name and address of person who

Smith, MD

TLS

12tVA

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

FRANKLIN DRUMHELLER

Teai Drive

Suite 301

taston MD 21601

completed cause of death (Item 23a) (Type, Print)

8221

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2008 **Physician** Kevin John Dwyer October 6, 9:48A. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Nov 3, 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 59 Months 1√□ M 2 □ F 118-38-9754 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Madical Examiner must be notified at Director 1 X Yes 2 □ No Rockville Maryland | Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code items 23a or 864 College Parkway 20850 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 15☐Yes 2☐No 14. Race - American Indian 11. Marital Status Black, White, etc ty Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 'natural', or 1 ☐ Yes 2 🔀 No Specify: white Specify: \$ 3<sup>™</sup> Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the way injury or other traumatic event, the way Elementary/Secondary (0-12) College (1-4or 5+) Printer Printing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Cecelia Cardon Howard Dwyer ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lisa Dwyer - daughter 122 Fairground Avenue, Hagerstown, Maryland Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State St. John's Cemetery 10-10-2008 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Sig at e of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 1 day Respiratory failure disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner l day Gram negative sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be executed 3 days Neutropenia Due to (or as a consequence of): burlal-Box 68760, attending physician for use as the burla Physician/Medical 6 mos Leukemia IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. ed by the a 9 Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t autopsy perform certificate 1 ☐ Yes 2 ☐ No Division of Vital 1 ☐ Yes 2 ( No Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | N 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this After thi 27, Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation (Month, Day, Year) 1 Natural Injury death. 1 ☐ Yes 2 ☐ No iours after death.

neral Director: #
filled in by the for 2 Accident Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 24 hours a Medical 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated npletely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 28 homan Duphre -tamus 31. Date filed (Month, Day, 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

**ORIGINAL** 

DHMH 17 Rev 1/200

State

Registrar

31. Date filed (Month, Day, Year)

OCT 0 9 2008

ORIGINAL

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Hazel Ann Ewing 17 2008 4c. County of Death 2008 0200 /Medical OCTOBER 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner CITIZENS Social Security Number GRALE NURSING 8. Date of Birth (Month, Day, Year, **Funeral** 1 □ M 2 🖫 F June 8, 67 1941 New York Director 215-36-7927 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r 28a-f shov notified at 1 ☐ Yes 2X No Director MD Harford Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be r 2200 Palomino Ranch 21078 U.S.A. Rd. Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. and 27 is marked other than "natural", or items 23 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify Specify: White 3 Widowed 4 Divorced other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker In home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Francis Birch Margaret Marion Casselberry 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald Ewing, Sr. 2200 Palomino Ranch Rd. Havre de Grace, MD 21078 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of H Important: If ite any Injury or of 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) R. A. Ferris & Co. 10/21/08 West Chester, PA 21. Signature of Funeral Servica Licenses 22. Name and Address of Facility
Tarring-Cargo Funeral Home, P.A. Tarring-Cargo Funeral Home Aberdeen, Maryland 21001
23a. Part1. Enter the disease, or complyations that daused the death. Do n enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Aberdeen, Maryland 21001-3399 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, and the conditions of the conditions Disa to for my neconsciousome offi-Examiner physician and s the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? this certificate has 2 No To the Hospital or Attending responsibilities to the Funeral Director: After this certifical contraction of the Funeral Director. After the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9100000

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 33685 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month LER Year NILLIAM 004UM 08 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Harwood

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth

Months | Days | Hours | Min. | 4 no. | 16 Arundel

9. Birthplace (State or Foreign Country)
Maryland Mandrin Hospice House Anne 7. Age (In yrs. last birthday) Social Security Number **Funeral** Sex 1 M 2 □ F Ja'n. 81 Ĩ′927 214-26-6712 Director Usual Residence of Decedent 10a. State 10b, County 10c. City. Town or Location show 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Modest Examinations to neither at Director 1∰Yes 2 No Maryland Anne Arundel Annapolis the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with Hygiene. 206 Bowie Avenue 21401 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☑ Married If Yes, Give 1 ☐ Yes 2 ☑ No Specify: Black þ Specify 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Anne Arundel Elementary/Secondary (0-12) College (1-4or 5+) General Hospital d 2 should be filed w th and Mental Hygien 7 is marked other th 7th 0 Gardner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Josephine Williams William J. Fuller Sr. ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is m any injury or other traumonce. Pearl Fuller (Wife) 206 Bowie Ave. Annapolis, Md. 21401 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Buria! 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bestgate Mem. Park 10/7/08 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sons Mortuary P2A Annapolis, Md. 21401 Reese sŧ. Larry & 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final HUL ANGI DCARCINOM **Physician** 6 0 1 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) physician and the burial-trans resulting in death) Last Due to (or as a consequence of) Physician/Medical attending p for use as use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) signed by the a 1 ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b 1 Yes 2 No 3 Probably 4 Unknown should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t page 2 s autopsy performed? certificate 2 No 1 □Yes 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 6 Dother (Specify) Hospital: Other: 4 Nursing Home 5 Residence 1∐Yes 2XNo After this o 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA MILE ication: To House 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation М 1 ☐ Yes 2 ☐ Accident 2 🗆 No the 6 ☐ Could not be 3 ☐ Suicide ber or Rural Route Number.

Division of Vital Records, P.O. Box 68760, all or Attending Physician: The law requires that the death certificate be executed

Baltimore, Maryland 21215-0036

Division of Vital Reco To the Hospital or Attending Physician: The law r within 24 hours after death.
To the Funeral Director: After this certificate has be completely filled in by the funeral director, page 2 sh

irs after or ral Directed in by	Certif	4 ☐ Homicide	determined		28t. Location (Street and Number or Rural Route Numi City or Town, State)							
n 24 hour ne Funera oletely fill	edical	29a. Certifier (Check only one)	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)									
To the	Me	29h Signature and	title of certifier	Henda	en.	29c. License number 0 2 1 4 3	8	29d. Date signed (Month, Day, Year)  Octuber 01, 2				
BOY	٦	30. Name and addr	ress of person who cor	npleted cause of death (Iten	23a) (Type, Print)	ENSE HIGHW	Ay A	NN APOLUM DZIYU				

State Registrar

31. Date filed (Month, Day, Year)

OCT 0 6 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year Month **Physician** Kenneth Ralph Faist 2008 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Regional Medical Center Wicomico Isbury If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days 1 XM 2 □ F 221-44-2468 Director 48 9-18-1960 Seaford, Delaware Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examinar must be notified at Director 1 XYes 2 No Sussex Laurel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number items 23a or 10029 Locust Street 19956 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2√☐ No Specify Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Disabled N/A 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Faist Mary Jane Faist 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Larry Faist</u> (brother) 10029 Locust St. Laurel, Delaware 19956 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Odd Fellows Cemetery | 9-24-2008 Seaford, Delaware 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 700 West Street 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Hannigan, Short, Disharoon F.H. Laurel, De. 19956 **Physician** disease or condition resulting in death) 1Grge /Medical Due to (or as a const uence of): Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to for as a consequence off To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) P.0. 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown ASCUD 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 ₩0 1 ☐ Yes 2 HNO 1∏Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ∐ Yes 2 ☑ No 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

3 m

State

29a, Certifier

29b. Signature and titl

31. Date filed (Mop

ohu

arrol

and manner stated

ess of person who completed cause of death (Item 23a) (Type, Print

151-11

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

10059368

29d. Date signed (Month, Day, Year)

08

MO 2180 4

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Death
 Month Day **Physician** Salome A. Gayle 1.0 3 2008 23:26 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** WashingtonAdventist Hospital Takoma Park
If Under 1 Year | If Under 24 Hrs. Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 □ M 2 🖾 F Director 578-84-9002 79 9/6/1929 Jamaica Usual Residence of Decedent 10c. City, Town or Location 10a State 10b County 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Experiment he multiple at Director YE Yes 2 □ No MD Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2310 Bannings Place USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☒No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 ☐ Yes 2 ☒ No Specify þ Specify: Black 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housekeeper Hote1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ Eulette Sharpe Albertha Sharpe 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Esmena Mullings/Daughter 4101 Stoconga Drive, Beltsville, Maryland 20705 20b. Place of Disposition (Name of Cook Pen Family)
Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 □XBurial 2 □ Cremation 3 □ Removal from State Mc 10/26/2008 Spanish Town, Jamaica 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fupa 22. Name and Address of Facility Marshalls Funeral Home 4217 9th Street, NW Washington, DC 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ongshiv disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Daw to (or as a consequence of) and burial-Due to (or as a consequence of) attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 🔼 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an icate has t autopsy performe 2 🐼 No 1 ☐ Yes 1 ☐ Yes 2 🗆 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1∐ Yes 2 MóNo Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After th funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Physician: The law requires that the death certificate be executed Box 68760, P.0. Division of Vital Records, certificate this

Baltimore, Maryland 21215-0036

Hospital or Attending

within 24 hours after death

To the Funeral Director:
completely filled in by the To the within 2

0

State Registrar

Medical

29a. Certifier (Check only one)

29b. Signature and t

Year) 31. Date filed (Month, Day,

of certifier



30. Name and address of person who completed cause of death (Hern 23a) (Type, Print) DAINDER SINGL. M.D.

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

45660

29d. Date signed (Month, Day, Year)

08-07710 Shelley Gonzalez

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

onelley Gonzalez	State of Maryland / Department of Health and Mental Hygiene  1- For State Registrar  Certificate of Death Reg. No. 2008 336
Physician/ Medical Examine	
Married Committee of the Committee of th	4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death
Funeral	Prince George's Hospital Center  Cheverly  Prince George's  5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)  If Under 1 Year   If Under 24Hrs.   8. Date of Birth (MM/DD/YYYY)   9. Birthplace (State or Foreign)
Director	214-70-4836 1 M 2 XF 50 Yrs. Months Days Hours Min. JULY 27,1958 MARYLAND
any	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
<b>*</b> .	MD. PRINCE GEORGES TUXEDO
ith the Maryland 23a or 28a-f sho notified at once	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
with the s 23a o e notifi	2412 57th PL. 20785 U.S.A.  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - American Indian, Black,
r death with or items 23 must be no	1 Never Married 2 X Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Ricán, etc.) White, etc.
ural",	3 Wildowed 4 Divorced in Yes, Give Year 1 Yes 2 X No specify: WHITE
72 hou nat sal Exa	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use retired)
5-0036 lied within 72 hours after death with the Maryland Hygiene. 4 other than "natural", or items 23a or 28a-f she the Medical Examiner must be notified at once Completed by Funeral Director	BEAUTICIAN COSMETICS  17. Father's Name (First, Middle, Last)  BEAUTICIAN COSMETICS  18. Mother's Name (First, Middle, Maiden Surname)
	19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Σ 5 € 2 1	ARDYTHE PETERS/MOTHER 2412 57th PL., TUXEDO, MD. 20785  20a. Method of Disposition (Name of cemetery, Date 20c. Location - City or Town, State
imore Pages 1 nent of F lant: If i	1 Burial 2 X Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: CHAMBERS CREMATORY 10-16-2008 RIVERDALE, MD.
Baltimore, permit. Pages I an Department of Hea Important: If iter injury or other tra	21. Signature of Funeral Service doensee  22. Name and Address of Facility CHAMBERS FUNERAL HOME & CREMATORTUM, P. A.
Physician	M00091 5801 CLEVELAND AVE., RIVERDALE, MD. 20737  23a. Part I. Enter the disease, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and
/Medical xaminer	Immediate Cause (Final disease or condition resulting in death)  a Hypertensive cardiovascular disease or condition resulting in death)  Due to (or as a consequence of):
	Sequentially list conditions.
red misit	if any, leading to immediate Due to (or as a consequence of):  cause. Enter Underlying Cause  (Disease or injury that initiated c
xecuted n and	
60, ate be execu hysician and te burial - tra	X UNPENDED 23a,PII,27, per ME g884 10/29/08 TT
ox 6876(eath certificate attending phy for use as the trisical relicions	FEMALE: 23c. If yes, outcome of pregnancy   23d. Date of delivery   23d. Was decedent pregnant in the past 12 months?   Live birth 2 Fetal death 3 Ectopic pregnancy   Month Day Year
	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Other (Specify)
that the detached detached	
duires transignation sign	Endstage renal disease  1 Yes 2 No 3 Probably 4 Unknown  24a. Was an 24b. Were autopsy findings available
Division of Vital Records, P.( ral or Attending Physician: The law requires tha as Director: After this certificate has been signed led in by the funeral director, page 2 should be der artification: To Be Completed by	autopsy prior to completion of cause of performed? death?
tal Recition: The certificate page	25. Was case referred to medical 26. Place of Death (Check only one)
Physici or this c ral direc	1 Ves 2 No Parient 2 ER/Outpatient 3 DOA Survey Home 5 Residence 6 Other:
ion of tending Pheath.  Jor: After the funeral	27. Manner of Death    28a. Date of Injury (Month, Day, Year)   28b. Time of Injury   28c. Injury at Work?   28d. Describe how injury occurred   1 Yes 2 No
Division ospital or Attending nours after death. neral Director: After filled in by the fune Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State)
Di ospital hours a uneral y filled	
Divis To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  One)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
F % F %	
	30. Name and address of person who completed cause of death (Item 23a)
	Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
State Registra	(U.) 1 / 718192   1584 - 179 177-487-487-18

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 10 **Physician** 0 Pay 2008 Henrietta Louise Gibbs 1:30 PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Oueen Anne's Church Hill 234 Buzzard Lane If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 □ M 2 □ F 08/07/1931 MD Director 217-28-4286 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Heath and Mental Hyglene. Important: If item 27 Is marked of the than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medi-al Examiner must be notified at any Injury or other traumatic event, the Medi-al Examiner must be notified at 1 ☐ Yes X☐ No Director Church Hill Md. Queen Annes 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code P.O.Bx 185 234 Buzzard Ln. 21623 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Hunnetta Oodel. D. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ Specify: 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own home 6 <u> Homemaker</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Beulah Heath Arthur Little Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Bennie Smith Funeral Home 426 Dover St., Easton, Md. 21601 George B. Gibbs/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/10/08 Grasonville, MD Robinson Cem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bennie Smith Funeral Home 426 Dover St. Easton, MD 21601 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 23a. Part1, Enter the disease, or comshock, or heart failure. List only Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ears, Chronic /Medical Due to (or as a consequence of): Examiner Cerebooraseu if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine law requires that the death certificate be executed anemo ed by the attending physician and detached for use as the burial-tran Due to (or as a consequence of): Box 68760. typerparally weder Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) P.O. | 9 Unknown this certificate has been signed by tral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1☐ Yes 2☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide ō 100 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral To the Hospital

11.5 3

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

00/60220

an's Lane, Easton, Md. 21601

OCT 0 8 2008



		·	For State Registrar	State of Ivia	-	ertificate			R	eg. No. 🤈 🗍	0.8	33	590
	Physici	an	1. Decedent's Name (First, Middle, Last Margaret A. Grigg						2. Date of Dea Month October	Day	Year	3. Time of 5:38	Death A <sup>M</sup>
and the same	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Tox	wn, or Loc	ation of Deat		4c. County		3:30	A
A. S.	LXamm	Ci	727 Mount Alban Di	rive		Annap	olis			Anne	Arur	de1	
	Funeral Director			7. Age	(In yrs. last birthd Yrs	Months   C		Under 24 Hrs ours Min.	8. Date of Birth (Month, Day Sept.8,	Year) 1910	9. Birth Coul Mary	place (State of htry) 'Iand	or Foreign
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location					1	0d. Inside Ci	ty Limits
	filed within 72 hours after death with the Maryland Hygiene. wher than "natural", or items 23a or 28a-f show ant, the Medical Examinat must be redified at	Funeral Director	Maryland Anne Art	undel	Ann	apolis	ode		1	1 ☐ Yes 2 No 10g. Citizen of What Country?			
	3a or	al Di	727 Mount Alban Dr	rive		214	09		Į	United States			
	ems ?	iner	11. Marital Status	12. Was Decedent Ev Armed Forces?	ver in U.S. 1	Was Deceden     If Yes, specify	t of Hispa Cuban, M	nic Origin? (S lexican, Puer	Specify Yes or No- to Rican, etc.)	14. Rad	e - Americ	can Indian,	
980	ours after ral", or it Examin	þ	1 ☐ Never Married 2 ☐ Married  XX Widowed 4 ☐ Divorced	1 ∐Yes 2 XXX If Yes, Give Year or Dates:		1 □Yes 2 🕅		pecify:		Specify			
5-0	72 hc "natu	etec	15. Decedent's Edu (Specify only highest grad	ucation de co <i>mpleted)</i>	16a. De	ecedent's Usual C live kind of work of e. DO NOT use i	occupation done durin	n g most of wo	rking	16b. Kind of Bu	usiness/In	dustry	
2121	iled within Hygiene. ther than '	Completed	Elementary/Secondary (0-12)	College (1-4or 5+	)	omemaker				0	wn Ho	me	
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan of Heath and Mental hygiene. itien 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, If a Medical Examirer must be retilled at	To Be (	17. Father's Name (First, Middle, Last)  John Francis Aumi.	ller			18. Mother's Name (First, Middle, Maiden Surname)  Margaret Maurer						
lary	2 should and his ma	-	19a. Informant's Name/Relationship (7)						ural Route Numbe				
	1 and 2 Health a em 27 is		Nancy L.Griggs Jol	hnson/Daug				Drive	Annapo.	lis, Ma:	_		)9
nor			20a. Method of Disposition  1 ☐ Burial XX Cremation 3 ☐ F  4 ☐ Donation 5 ☐ Other (Specify)	Removal from State		sposition (Name crematory or other		10//			•		1
Baltimore,	artro		21. Signature of Funeral Service Licens		Baltimo	re Crema 22. Name and			/2008   I ohn M. Ta	Baltimo: avlor F			
ã	Depa Impo any i		Mill of Dean			147 Duke	of		ster St.	•			•
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only o									Approximate Interval Bet Onset and I	ween
-	Physician		Immediate Cause (Final disease or condition resulting in death)	a	MIDDL	e léreis	3R4L	ARTE	ERY INF	TARCTI	ON	10 d	ays
- A	/Medical Examiner		resulting in deathy	Due to (or as a	consequence of):	A TO	CAR	NOVA	SCULAR	Disa	1-	10 41	2010
		Jer	Sequentially list conditions, if any, leading to immediate		consequence of):	KOIIC	C-//\1	31000	3 Ca DAN	Dise	7313	100	1000 %
	acuted ind transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		RTENS								
68760,	rificate be executed by physician and as the burial-transit	edical Ex	resulting in death) Last	Due to (or as a	consequence of):	rive l	)ISK	Dise	EASE				
. Box 68	eath cer attendir for use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	23c. If yes, outcome o 1 ☐ Live birth 2 4 ☐ Pregnant at 1	Fetal death	3 ☐ Ectopic preg					te of deliv		Year
P.0	at the de by the stached	hys	9 Unknown	9 Unknown					1				
	res tha signed I be del		DENENTIA MUL			e underlying caus	se given ir	Part I.	23e. Did to	bacco use conf es 2 No		ne cause of c	
Ö	w requir been s should	eted	32.73		,				24a. Was a				
Vital Records,	he law e has	Completed by					•		autop perfor	sy med?	prior to co death?	ppsy findings impletion of c	ause of
ital	sician: The la certificate ha irector, page 2	Be C	25. Was case referred to medical				26	. Place of De	1 ☐ Yes ath (Check only or	-	1 □ Yes	2 No	
of V	Physician: r this certifica ral director, p	70 E	examiner? 1 ☐ Yes 2 ANo	Hospital: 1 ☐ Inpatien	t 2 ER/Outpa			4 ☐ Nursing I	Home 5 Resid	ence 6 Oth	ner (Speci	fy)	
ono	fe		27. Manner of Death  1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day,	Year) 28b. Tim Inju	e of 28c ry M	. Injury at Work? 1 □ Yes	2 🗆 No	28d. Describe h	ow injury occur	red		
Division	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injur building, etc.	ry - At home, farm (Specify)	, street, factory, o	ffice		28f. Location (S City or Tow		per or Run	al Route Num	nber,
	e Hospita 24 hours e Funera iletely fille	Medical C	29a. Certifier 1 Certifying Phyone) 2 Medical Exam	ysician: To the best of niner: On the basis of and manner stat	examination and/o	leath occurred at or investigation, in	the time, my opini	date and place on, death occ	ce, and due to the curred at the time,	cause(s) and m date and place,	anner as and due t	stated. o the cause(s	5)
	To the vithin comp	ž	29b. Signature and title of certifler	W			3 i 9	mber 97		29d. Date signe	d (Month,	Day, Year)	
,	(14)		30. Name and address of person who c				Ci-	17-17-	1.1				
	(A) (Sta	to	HND REW GORDON  31. Date filed (Month, Day, Year)	32. Patristra	パロ(CA)	-TKUNY	JE 1	00,	ANN APO	ILIS, M	15	2140	1
	Sta Registr		OCT 0 6 2	008 Street	's Signature	hours							
DH	MH 17 Rev 1/2	001				DRIGINAL							

TLS 5+1

Registrar

29b. Signature and title of certific

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

010

Registrar's Signature

29c. License number

CHMANS

29d. Date signed (Month, Day, Year)

**ORIGINAL** 

DHMH 17 Rev 1/2001

			State of Maryland / Department	artment of Health and N rtificate of Death		ne.2008 33693
			1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	3. Time of Death
	Physici /Medic		Hervey L. Haines		October	6, 2008 10:17 P <sup>M</sup>
-	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
-97			311 Budds Landing Road	Warwick		Cecil
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birthplace (State or Foreign Country)
	Director		182-32-1/86		Dec. 5, 1	.940 Maryland
	pur w		Usual Residence of Decedent  10a, State 10b, County 10c, City, Town or Lc	cation		10d. Inside City Limits
	laryk sho	ō				1 □Yes 2 XNo
	28a-1	ect	Maryland Cecil Warwic	K 10f. Zip Code	10g.	. Citizen of What Country?
	filed within 72 hours after death with the Maryland Hygiene. yther than "natural", or items 23a or 28a-f show ant, it s mydical Evan har out be notified at	Funeral Director	311 Budds Landing Road	21912		USA
	ns 23	era		Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - American Indian,
10	fter d	Fun	1 □ Never Married 2 🕅 Married 1 □ Yes 2 🖼 No		Rican, etc.)	Black, White, etc.
215-0036	urs a al", o	þ	3 ☐ Widowed 4 ☐ Divorced	1 □Yes 2 🛛 No Specify:		Specify: White
2-0	2 ho	Completed by	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of work	ding 16t	b. Kind of Business/Industry
21	thin 7	du	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)		
21	ed wi	ပ်		o Worker		Nuto Manufacturing
nd	d oth	Be	17. Father's Name (First, Middle, Last)		ne (First, Middle, Mai	den Surname)
yla	Men Men arke	ျ	George Lamar Haines	Miriam I		
Maryland	2 short and is m			ng Address (Street and Number or Ru		
6	and tealth m 27 her t	ļ.		Budds Landing Road		c. Location - City or Town, State
000	ges 1 It of H If ite or ot		20a. Method of Disposition  1  ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  20b. Place of Disposition cemetery, cre	sition (Name of natory or other place)	Date 200	5. Education - City of Town, State
Ę,	t. Pa tmer tant:				L1-2008 R	Rising Sun, Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, It is in a fired. Even in a cost in a conce.		$\mathbb{R}$	<ol> <li>Name and Address of Facility</li> <li>T. Foard Funeral</li> </ol>	Home, P.	A.
			Keepard a Soodie 11	1 S. Queen Street	. Rising	Sun. MD 21911
			23a. P. rt.1. Enter the disease, or complications that caused the death. Do not en a lock, or heart failure. List only one cause on a line.	0	or respiratory arrest	Interval Between Onset and Death
	Physician // // // // // // // // // // // // //		Immediate Cause (Final disease or condition resulting in death)	Cancer		
4	Examiner		Due to (or as a consequence of):			
		-	Sequentially list conditions, if any, leading to immediate b.  Due to (or as a consequence of):			
	nsit	Ë	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.			
,	exection and all-tra	Examiner	resulting in death) Last			
8760,	ficate be executed physician and s the burial-transit	dical	d			
89	ifficat g phy as the	edi				
Вох	leath certific attending p	N/	IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3	75		23d. Date of delivery
m.	death e atte d for	Physician/Me	in the past 12 months?  1	☐ Ectopic pregnancy ☐ Other (specify)		Month Day Year
P.0	t the by th ache	hys	9 Unknown			
	The law requires that the death certif ate has been signed by the attending page 2 should be detached for use as	by P	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	/	cco use contribute to the cause of death?
Records	w require s been si should b				1 N Yes	2 No 3 Probably 4 Unknown
oc o	e law re has be e 2 sho	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
Ä	: The I	E O			performe	ed? death?
Vital		Be C	25. Was case referred to medical examiner?	26. Place of Dea	th (Check only one)	
f V	Physician: this certific ral director,		examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	nt 3 ☐ DOA Other: 4 ☐ Nursing H	lome 5 Residence	ce 6 ☐ Other (Specify)
J Of	ding Physician:  After this certific funeral director,	Ë	27. Manna of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 1 Injury	f 28c. Injury at Work?	28d. Describe how	injury occurred
Ö		atic	2 Accident investigation	M 1 □Yes 2 □No		
Division	r Atterderinecto	Certification: To	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)
	italo Irs afl ral Di	Cer				
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: / completely filled in by the fi	Medical	29a. Certifier  (Check only (			
	To the within 2 To the Comple	Med	one) and manner stated.  29b. Signature and title of certifier	29c. License number	29d	d. Date signed (Month, Day, Year)
	5 ≥ <b>5</b> 8	_	Sold Signature and the street of third	7	/	10/00/00
	1		J WWY	1000004081	0	10/08/08
	6		30. Name and address of person who completed cause of death (Item 23a) (Type	1 70 High St	Sto In	4 Elkton, MD21921
	∞ Sta	ate :	31. Date filed (Month, Day, Year) 32. Registrar's Signature	Willigh SI	01010	1 011-1411 11 01101
	Reaist		OCT 0 9 2008 Acres & COCH			

Hervey L. Haines 10/6/2008 10:11

Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 33694 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** 2008 1626 M Hurchalla October Marion Patricia /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner SAUISBUR Hiconica ROGIONAL If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Yea 3/17/1924 Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday Funeral Days Months 1 □ M 2 🗙 F 84 197-12-1183 Pennsylvania Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State show other traumatic event, the Medical Examiner must be notified at 1 XYes 2 □ No Director Wicomico Salisbury Maryland 28a-f 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ò 21801 USA or items 23a 208 Brooklyn Ave. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2**X** If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: <u>ک</u> Specify: white 3 ₩ Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) domestic housewife 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Anne McBarron James Crielly ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 208 Brooklyn Ave., Salisbury, MD 21801 Michael E. Hurchalla/son 27 Department of Healt Important: If item 2 any Injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages ' 1 ☐ Burial 2 【A Cremation 3 ☐ Removal from State 10/7/08 Salisbury Crematory Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) nature of Funeral Service Licensee PHOTEWAY Pringral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Kena disease or condition resulting in death) /Medical Due to (or as a consequence of) Heat Facture Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner burial-transi s a consequence of): resulting in death) Last Due to (or physician a the burial-Box 68760, certificate be Physician/Medical nding p use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant atten 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? for Month Vear 5 Other (specify) detached the o 9 Unknown signed by 1 d be detach ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No 1 □Yes Attending Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this o Certification: To To the Funeral Director: After the completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 🗷 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined or A 4 Homicide To the Hospital within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Definition and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month. Dav. Year) 29c. License number 29b. Signature and title of certifie

120

197-12-1183

State Registrar 100 E. CARROLL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Keim

STEPHEN

D 32212

SAlisbury Md 21801

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** IACK SON 08 10 02 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ANNAPOLIS ANNE ARUNDEL ANNE ARUNDEL MEDICAL CENTER Year If Under 24 Hrs. 8. Date of Birth NOV 22 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year)936 1 ☑ M 2 □ F Months Days Hours Min. N Carolina 579-46-5886 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Wodical Evaluitment unstibuted 1 □Yes 2 No Crownsville Maryland Anne Arundel Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? USA 1283 Bacon Ridge Rd. 21032 death v Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or item any injury or other traumatic event, the Wedical Examples. Black, White, etc. 1 ☐ Never Married 2 Married by 1 ☐Yes 21 No Specify. **Black** Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th 0 Self Employed Landscaper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mittie Anthony William Jackson Sr. ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances A. Jackson(Wife) 1283 Bacon Ridge Rd. Crownsville, Md. 21032 20c. Location - City or Town, State 20a. Method of Disposition 20b. PlacetofiDisposition (Name of cemetery, crematory or other place) Date 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Annapolis, Md. Memorial Gardens 10-8-08 4 ☐ Donation 5 ☐ Other (Specify) Manne Romassof Acinsons Mortuary, P.A. 21. Signature of Funeral Service Licensee 821 West St. Annapolis, Md. 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** VENTRICULAR TACHY CARDIA 30 minutes /Medical Due to (or as a consequence of): **Examiner** YEARS CARDIO MYDRATH Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 | Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? \$ DIAUSIS - DEPENDENT RENAL FAILURG 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed POSSIBLE SEPSIS 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No 24a Was an autopsy performed? 1 □Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 □Yes 2 □No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

D66753

30. Name and address of p who completed cause of death (Item 23a) (Type, Print)

MEDICAL PARKWAY, ANNAPOLIS MD 21401 CAPSTACK 2001

State Registrar

31. Date filed (Month, Day, Year) 0CT 0 6 2008

gistrar's Signature

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** Johnson October 15: 28 PM Steve 3 2008 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs. Months | Davs | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F Months Days 44 219-84-7036 MARYLAND SEPT 20, 1964 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10a State 10h County rai", or items 23a or 28a-f show Examiner must be notified at 1 X Yes 2 □ No Director MARYLAND HARFORD HAVRE DE GRACE 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 235 TIDEWATER DRIVE 21078 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: BLACK <u>Ş</u> 3 Widowed 4 Divorced "natural" Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) other than MATERIAL HANDLER MANUFACTURING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) B is marked STEVE WESLEY JOHNSON, SR. ELLEN M. BOND ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trau once. ELLEN M. BOND-JOHNSON / MOTHER 235 TIDEWATER DRIVE, HAVRE DE GRACE, MARYLAND 21078 Date 20c. Location - City or Town, State 20a Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ST. JAMES CEMETERY 10/10/08 HAVRE DE GRACE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility LISA SCOTT FUNERAL HOME, P.A.

552 LEWIS STREET, HAVRE DE GRACE,
shock, or heart failure. List only one cause on each line. 21. Signature of Funeral Service Licensee MD 21078 Approximate Interval Between Onset and Death mmediate Cause (Final ALVEOLAR HEMORRHAGE **Physician** Necks disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) attending physician a I for use as the burial Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 2 No Division of Vital Records, P.O. the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 2 No 3 Probably 4 Unknown Large mphoma Completed should Deen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has performed' 2 **N**0 2 No certificate 25. Was case referred to medical 26. Place of Death (Check only one) Physician: Be examiner?
1 Yes 2 MNo Hospital: 1 Z⊋npatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) မ this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. 28d. Describe how injury occurred Injury at Work? Certification: Hospital or Attending After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No neral Director: Af 2 Accident death. 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide e Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier October 3. 2008 RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) + IVA VERONIQUE MUSIEMBLATT 600 North Wolfe St, Baltimore, MD, 21287 31. Date filed (Month, Day, Year) Registrar's Signature State OCT 0,8 2008 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year October Physician Thelma Marie Gordy Jones 2008 P 3:15 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner wicomico Wicomico Nursing Home Salisbury If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 🛛 F 212-03-4698 91 6/24/1917 Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f shov dical Examiner must be notified at 1X Yes 2□No Director Salisbury Maryland Wicomico 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 900 Booth Street 21801 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Bace - American Indian. 11 Marital Status Black, White, etc. filed within 72 hours after 1 Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No Specify: Specify: ģ white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) shirt manufacturing seamstress Department of Health and Mental Hygie Important: If Item 27 is marked other i any injury or other traumatic event, <u>tt</u> once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be in nent of Health and Mental Grace Elizabeth Jones William B. Gordy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 107 Lakeview Dr., Salisbury, MD 21804 19a. Informant's Name/Relationship (Type. Print) Marguerite G. Smith/sister Date 20h Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Wicomico Memorial 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 10/8/08 Park Salisbury, MD 21. Signature of Funeral Service Licensee Holloway Funeral Home Professional Association David H. 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine requires that the death certificate be executed Due to (or as a consequence of): burialattending physician Physician/Medical the as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown 23d. Date of delivery 3 ☐ Ectopic pregnancy for Month Year Dav 4 □ Pregnant at time of death 5 ☐ Other (specify) 9 Linknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Unknown 1 ☐ Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an has page 2 autopsy this certificate | 2 No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be No No Other: Nursing Home 5 Residence 6 Other (Specify) 1 Tes 1 🔲 Inpatient 2 ER/Outpatient 3 DOA ပ္ 27. Maprier of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: Hospital or Attending 5 ☐ Pending investigation **Y** ☐ Natural 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death

To the Funeral Director;
completely filled in by the 6 □ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Mahesha Thimmarayappa M.D. 614 Easter 614 Easternshore Dr Salisbury MD 21804 32. Re strar's Signature State 2008 Registrar

DHMH 17 Rev 1/2001

3altimore, Maryland 21215-0036

P.O. Box 68760,

Division or Vital Records,

ena Kohn		State of Maryland / 1- For State Registrar	-	ment of ficate of		nd Menta		20 ag. No.	08 3369
Physicia Medical Exami		1. Decedent's Name (First, Middle,Last)  Dena Sara KOHN					2. Date of Dear Month October 6	th Day Year , 2008	3. Time of Death 1400 hrs
		4a. Facility Name (if not institution, give street and number) 8012 Brett Drive Place			Greenbelt			4c. County of Dea	ge's
Funeral Director		220-08-9033 <sub>1_M 2</sub> X <sub>F</sub>	(In yrs. last I	birthday) Yrs.	If Under 1 Ye	ear If Under 2	Min. Sept.	23, 1985	Birthplace (State or Foreign Constity) Maryland
nd how any ce.	_	Usual Residence of Decedent  10a. State 10b. County 1  Maryland Prince Georges	-	wn or Location					10d. Inside City Limits  1 Yes 2 X No
th the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Number 8012 Brett Place			10f. Zip Code 2077		1	Og. Citizen of What Co United St	
b, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she trammatic event, the Medical Examiner must be notified at once	by Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 Married 12. Was Decedent E Armed Forces? 1 Yes 2 Married 12. Was Decedent E Armed Forces?		If Yes		an, Mexican, Pu	( Specify Yes or No erto Rican, etc.)	White, etc.	erican Indian, Black, white
136 hin 72 hours a e. than "nature edical Exami	Completed b	15. Decedent's Education (Specify only highest grade comp Elementary/Secondary (0-12) College (1-4 or 5-		during mo:		ation (Give kind fe. DO NOT use ked		16b. Kind of Busines	s/Industry
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical	Be	17. Father's Name (First, Middle, Last) Gary Jacob Kohn				18.Mother's Nik	lame (First, Middle, I i Cohan	Maiden Surname)	
, MD 2. and 2 should ealth and M em 27 is ma	To	19a. Informant's Name/Relationship (Type, Print) Niki Cohan, Mother 20a, Method of Disposition	1	8012 B		lace, G	reenbelt,	nber, City or Town, Sta MD 20770 20c. Location - City	
Baltimore, permit. Pages I an Department of Her Important: If ite	1	1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify 21. Signature of Fureral Service License	e cren	en of	r place) Remembi	rance M		rk Clarks	
Physician Physician	1	23a. Part I. Enter the disease, or complications that caused the failure. List only one cause on each line.	ne death. Do				w Funeral <u>NW, Wash</u> acorréspiratory arr		20012 Approximate Interval
/Medical xaminer		Immediate Cause (Final disease or condition resulting in death)  a. Anorexia I Due to (or as a consection)		sa & Bu	ıllemia				Between Onset and Death
	miner	Sequentially list conditions, if any, leading to immediate course Enter 11 certains Course (Disease or injury that initiated				Н			
0, be executed sician and ourial - transit	edical Exa	ga							
our sici	sician/M	FFEMALE: 23c. If yes, outcome of pregnancy   23d. Date of deliver						ery Day Year	
, P.O. B res that the d signed by the	by Phy	Part II. Other significant conditions contributing to death	out not resul	Iting in the un	derlying cause	given in Part I			to the cause of death?
Division of Vital Records, P.O. Box 6876 the flospital or Attending Physician: The law requires that the death certificate hin 24 hours after death the funeral Director: After this certificate has been signed by the attending phyphelety filled in by the timeral director, page 2 should be detached for use as the	Completed						1 Yes	prior to prior to death'	autopsy findings available o completion of cause of ? Yes 2 No
Vital ysician: this certit	To Be	25. Was case referred to medical examiner?  1 ✓ Yes 2 No  Hospital: 1 Inpatient	2 ER	₹/Outpatient	p====	Other N		Residence 6 🗸 Oth	ner: Scene
ion of tending Pheath	ation: T	27. Manner of Death  1 X Natural 5 Pending 2 Accident Investigation	28 ar)	b. Time of Inj		ury at Work? Yes 2 No	1	how injury occurred	
Division To the Hospital or Attence within 24 hours after death To the Funeral Director:	Certification:	3 Suicide 6 Could not be determined (Specify)	ry - At home	e, farm, street	, factory, office	building, etc.	28f. Location (S or Town, S		Rural Route Number, City
To the Hos within 24 h To the Fur completely	Medical	29a. Certifier (Check only one) 2 Medical Examiner: On the best of my my done) 2 Medical Examiner: On the basis of examiner and manner stated.			n, in my opinio	on, death occur		and place, and due to	the cause(s)
	Σ	29b. Signature and title of certifier				.M.E.		29d. Date signed (A October 7, 200	
		<ol> <li>Name and address of person who completed cause of dea Russell Alexander MD. Assistant Medica</li> </ol>	,	,	Penn Stree	t, Baltimore	, MD 21201		
St Regist	ate	31. Date filed (Month-Day Year) 2008 32 Registrar's	Signature	San and A	53				

Examiner The law requires that the death certificate be executed and burial-tran Division or Vital Records, P.O. Box 68760, physician attending | should be certificate funeral director, Hospital or Attending

after death Director: To the Hospital o within 24 hours aff To the Funeral Di completely filled ir

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

death with the Maryland

be filed within 72 hours after

al Hygiene.

permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Important; If Item 27 is marked othany Injury or other traumatic event

Physician

Baltimore, Maryland 21215-0036

1241 Registrar

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Harry Li, 8600 Snowden River Parkway Suite 301 Columbia, Maryland

31. Date filed (Month, Day, Year) **DOT 0 8 2008** 

4 ☐ Homicide

29b. Signature and title of certifier

29a. Certifier (Check only one) determined

32. Resistrar's Signature

m.D.

1 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

October 8, 2008

08-07534 Joann Lyon

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2008 33700 State of Maryland / Department of Health and Mental Hygiene perMD, FCHD, SC Certificate of Death 10/16/08 Amended#1 3. Time of Death 2 Date of Death Month Day October 5, 2008 1. Decedent's Name (First, Middle,Last) 1730 hrs Physician/ Joanne Fischetti Lyon Me∤ Examiner Fischett 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore** University Hospital Shock Trauma 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Hours Min Months New York Director 48 5, 1960 2 XF 108-54-9070 М Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State Yes 2 X No Frederick Frederick Maryland 23a or 28a-f shov 10g. Citizen of What Country? Director 10f, Zip Code 10e. Street and Number United States 21701 9014 Spring Meadow Circle 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Was Decedent Ever in U.S. Funeral 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 2 XMarried Never Married 2 X No Yes White Specify: Yes 2X No specify: Divorced If Yes, Give Year Widowed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done ģ 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) Accounting Business Owner 21215-0036 Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Charlene Griffen it: If item 27 is marked other traumatic event, i Richard Fischetti Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print ) ဂ္ QE. 9014 Spring Meadow Circle, Frederick, MD 21701 Joe Lyon / Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) Baltimore, Burial 2 Cremation 3 Removal from State 10/10/2008 Frederick, Maryland Stauffer Crematory portant: ury or otl Donation 5 Other Specify: Stauffer Funeral Home 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 1621 Opossumtown Pike, Frederick Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only but cause on each line. Tau Between Onset and vsician /ledical a Multiple Injuries Immediate Cause (Final disease Examiner Due to (or as a consequence of): or condition resulting in death) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): certificate be executed and Physician/Medical AMENDED physician a UNPENDED 23d. Date of delivery 23c. If yes, outcome of pregnancy Box 68760 IF FEMALE: Year Month Day 3 Ectopic pregnancy 3b. Was decedent pregnant in the Fetal death use as t past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 V Unknown detached for 23e. Did tobacco use contribute to the cause of death? the contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions P.0 1 Yes 2 ✓ No 3 Probably 4 Unknown ò 24b. Were autopsy findings available 24a, Was an Completed Records, has been s 2 should b prior to completion of cause of autopsy death? performed? 1 V Yes certificate has ✓ Yes 2 No page 26.Place of Death (Check only one) 25. Was case referred to medical To the Hospital or Attending Physician: funeral director, Division of Vital Be Other<sub>2</sub> Residence 6 Other Hospital: 1 Nursing Home 5 examiner? Inpatient 2 V ER/Outpatient 3 1 ✔ Yes No 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury 28b. Time of Injury After t Motorcycle passenger involved in collision 27. Manner of Death Oct 5, 2008 1620 hrs 1 Yes 2 ✔ No Natural Pending Director: d in by the the hours after death. 28f. Location (Street and Number or Rural Route Number, City Investigation 2 🗸 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) Route 27 at East Ridgeville Blvd, Mount Airey , MD Could not be 3 Suicide determined (Specify) Major Road / Highway Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal 29d. Date signed (Month, Day, Year) 29c. License number 2 29b. Signature and title of certifier October 6, 2008 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201

31. Date filed (Month, Day, Year) OCT 0 9 State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Assistant Medical Examiner

State of Maryland, Poepart Gent of Health and Mental Hygien ? 1 - For State Registrar Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Oct. 15<sup>Day</sup> **Physician** 200<sup>Year</sup> William Kipling At Lee, Sr. 1650 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Calvert Memorial Hospital Prince Frederick Calvert If Under 1 Year If Under 24 Hrs. Nonths Days Hours Min. 8. Date of Birth (Month, Day Year) Aug. 23, 1914 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 N Y 6 Sex **Funeral** 1**∑**M 2□ F Months 107-18-7419 94 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10h Counts 10a State 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hyglene. Important: if item 27 is marked other then "naturel", or items 23a or 28a-f ehow any njury or other treumatic event. The Madical Exam ner must be notified at 2056. MD Calvert 1 Tyes 2 XNo by Funeral Director Huntingtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3326 Holland Cliffs Road 20639 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🗷 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White 3 XWidowed 4 □ Divorced Completed Boy Scouts of 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Scout Executive America 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be F. Porter At Lee Harriet Kipling 2 1953 Mailing Address (Street and Number of Rural Royle Number, City or Town, State, Zip Code)
Huntingtown, MD 20639 19a. Informant's Name/Relationship (Type, Print) Huntingtown, W. Kipling At Lee, Jr. /son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3X Removal from State Metro. Crematory 10/16/08 Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sewell 1451 Dares Beach Rd. Funeral Home Pr. Fred., 21. Signature of Funeral Service License <del>\$</del> 20678 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ASUSTOR disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Pleural Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Physician/Medical Examiner nding physician end use as the burial-transit to the Hospitel or Attending Physician: The law requires that the death certificate be executed HUA resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant or u 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown ate has been signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 1 🗌 Yes 2/2N0 1 Yes director. Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No 1 X cpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA After the 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending r death. 1 ☐ Yes 2 ☐ No investigation hours after deat uneral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) amban 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FOAD PRINCE FREDERICK,

DHMH 17 Hev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

22

2008

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** 1425 Octoner 2008 JEFFRY A. MILES /Medical 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospital General Darchester Dorchester Cambridge If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1**X**) M 2□ F 40 212-06-7800 MARYLAND Director JULY 30,1968 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10b. County 1X Yes 2 No EASTON Directo MD TALBOT 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö must be USA 21601 23a 29513 GOLTON DRIVE Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian or Items 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 No Specify: WHITE à 3 ☐ Widowed 4X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) FLOORING INSTALLATION OWNER 12 other 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be ROSE ANITA SWARTZ VERNON E. MILES, SR. 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 29513 GOLTON DRIVE, EASTON, MD 21601 ROSE ANITA SWARTZ/MOTHER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition permit. Pages 1 Department of H Important: If ite any Injury or ot 1 K Burial 2 ☐ Cremation 3 ☐ Removal from State SPRING HILL CEMETERY 10/10/2008 EASTON, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST., EASTON, MD 21601 MERCERON K NHOK 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical consequence of) Due to (or as a Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. physician Physician/Medical as attending 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4□Pregnant at time of death 5 ☐ Other (specify) Yes 2 □ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate 1□ Yes Hospital or Attending Physiclan: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 Nnpatient 2 ER/Outpatient 3 DOA 2 this 27. Manner of Death . Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After t 1 Natural 5 Pending investigation I Director: A d in by the f 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours after To the Funeral Dire 29a. Certifier 1 💢 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month

0

IRK

ie fry

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 33703 Reg. No. 2 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death cctober John Francis McGowan, Jr. 0900 M Ob DOCE 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Easton Taibot Hospital at Easton 9. Birthplace (State or Foreign New York 5. Social Security Number 023-24-8389 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 7 (Month 2 Day 9 3 4 Min. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits St. Michaels Talbot 1XYes 2□No

Physician /Medical Examiner 1 - For State Registrar

10a. State

Md

ō

**Physician** 

/Medical

Examiner

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlia-transit

Division or Vital Records, P.O. Box 68760,

rec	10e. Street and Number	1	Of. Zip Code	10g.	10g. Citizen of What Country?						
al Di	400 Water Street		21663		USA						
Be Completed by Funeral Direc	11. Marital Status  1 □ Never Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U Armed Forces?  1 ☑ Yes 2 □ No If Yes, Give Year or Dates: Na V Y	40	Decedent of Hispanic Origin? (Ss. specify Cuban, Mexican, Puer	14. Race - American Indian, Black, White, etc.  Specify: White							
eted	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent'	s Usual Occupation of work done during most of wo NOT use retired)	rking 16t	. Kind of Business/Ind	ustry					
dmo	Elementary/Secondary (0-12) College (1-4or 5+) 12 years 5 years		Pechnologist		fizer						
Se C	17. Father's Name (First, Middle, Last)		18. Mother's Na	me (First, Middle, Mai	den Surname)						
P	John Francis McGowan, Sr.	T		rine Harg							
	19a. Informant's Name/Relationship (Type. Print) Sandra McGowan (wife)		ater St., St.			Code) 1663					
	1 Puriol 2 Comption 2 Pamoval from State	_	ry or other place) Crematory 10-	-7-2008	Dover, Do	e.					
	21. Signature of Funeral Service Licensee	22. Na R • P • (	me and Address of Facility  Carroll Hurl  D. Box 518, S	ley Funer St. Micha	al Home, els, Md.	PC 21663					
	resulting in death)	th. Do not enter th		c or respiratory arrest,		Approximate Interval Between Onset and Death					
Examiner	Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):										
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  IF FEMALE: 23c. if yes, outcome pf pregnant at time of 9 □ Unknown	al death 3 □Ect	opic pregnancy ner (specify)		23d. Date of delivery Month Day Year						
ed by Ph	Part II. Other significant conditions contributing to death but not res	sulting in the under	lying cause given in Part I.		co use contribute to th						
Complete				24a. Was an autopsy performer 1∐ Yes 2	prior to cor death?	osy findings available npletion of cause of 2 No					
Be (	25. Was case referred to medical examiner?			ath (Check only one)							
10 1		ER/Outpatient 3 28b. Time of Injury		Home 5 Residence 28d. Describe how	e 6 □Other (Specify injury occurred	/)					
Solicide    Solicide   Could not be determined											
										M	and manner stated.  29b. Signature and title of certifier  30. Name and address of person who completed cause of death (Itell Party 2)  31. Date filed (Month, Day, Year)  32. Pigistrar's Sign
<	30. Name and address of person who completed cause of death (Ite	m 23a) (Type, Prin	4- Sheet ; X	Seuton M	0 2162	9					
ate rar	31. Date filed (Month, Day, Year) 32. Digistrar's Sign	ature	est o								

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PK 5+1 VA

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Lenora Todd McMahan 9:50 a.™ 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5058 Aireys Road Cambridge Dorchester 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months Hours Days 1 □ M 2**X** F 214-07-9707 90 Director March 1, 1918 Maryland Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits ıral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 🌂 ☐ No MD Dorchester Funeral Director Cambridge 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. 5058 Aireys Road 21613 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Completed by Specify: white 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) iene. Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked any injury or other traumatic evonce. Sangston Waylon Todd Florence Bradford 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tyann Gore daughter 5058 Aireys Road, Cambridge, MD 21613 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Dorchester Mem. Park 10/6/08 Cambridge, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A.

**Physician** /Medical Examiner

Examiner

ed by the attending physician and detached for use as the burial-tran s been signed by to should be detach ours after death.

neral Director: After this certific filled in by the funeral director,

law requires that the death certificate be executed

To the Hospital or Attending Physician: within 24 hours after death.

Division or Vital Records, P.O. Box 68760,

ノーハ・レン		700 Locust St., Cambridge,	MD 21613	
23a. Part1. Enter the disease, or o shock, or heart failure. List of	complications that caused the death. Do not only one cause on each line.	t enter the mode of dying, such as cardiac or respiratory arrest	t,	Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a consequence of)	1-20A4		
Sequentially list conditions, and y, cause. Enter Underlying Cause (Disease or injury that initiated events	b	ė.		
resulting in death) Last	Due to (or as a consequence of):			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ 10 He	23c. If yes, outcome pf pregnancy 1	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	23d. Date of delive Month	very Day Year

Physician/Medical 9LJUnknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 🕦 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ 100 24a. Was an autopsy perform nfection 1∐ Yes 2 100 Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 | Yes 2 | ₩6 Other: 4 Nursing Home 5 Desidence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier Ecertfying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical

and manner stated. 29b. Signature and title of certifie

dame and address of person who completed cause of death (Item 23a) (Type, Print) 315 NARR

State Registrar 31. Date filed (Month, Day,

		State     Registrar	State of Marylan	d / Depa <i>Cer</i>	rtment of H	ealth and l Death		giene Reg. No. 20	08 33705		
Physicia /Medic	al	1. Decedent's Name (First, Middle, Last)     Robert Ernes  4a. Facility Name (If not institution, give stre			4b. City, Town, or	Location of Death	2. Date of Dea Month	Day	Year 3. Time of Death  Year 1650 M		
Examin Funeral Director	er	Pen In SULA         RESIDNA           5. Social Security Number         6. Sex           213-22-8145         ¹X∑ №	7. Age (In yrs.	//////////////////////////////////////	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da 5/16/19	h y, Year)	9. Birthplace (State or Foreign Country) Maryland		
perillingte, Mary fall of ALZ 13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I flem 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Experience must be redified at once.	Completed by Funeral Director	Usual Residence of Decedent  10a. State  10b. County  Maryland  10c. Street and Number  202 E. Church Street  11. Marital Status  1  Never Married 2 Married 3  Widowed 4 Divorced  15. Decedent's Educat  (Specify only highest grade of Parkets)  Elementary/Secondary (0-12)	Was Decedent Ever in U. Armed Forces? 1 Xes 2 □ No If Yes, Give Year or Dates: Army	16a. Deced	lation  10f. Zip Code 21830  Vas Decedent of His Yes, specify Cubar  In Yes 2 Man No  ent's Usual Occupation of work done diagnostic of NOT use retired)  crician	Specify:	pecify Yes or No- o Rican, etc.)	Specify:	- American Indian, , White, etc. white		
ryland hould be file id Mental Hy marked othe matic event,	To Be (	17. Father's Name (First, Middle, Last) Elton Maddox  19a. Informant's Name/Relationship (Type.	Print	10h Mailin	g Address (Street a	Martha	Dickers				
standss thealth an item 27 is a		Doris Mae Maddox/1  20a. Method of Disposition	wife	202	E. Churc	h St., H	ebron, N	1D 21830	City or Town, State		
Dalkinor Dearmit. Pages Department of Mportant: If it any Injury or o	- {	1 ☑ Burial 2 ☐ Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)  21. Ignature of Juntar State In Insee	iovai from State	oron Ce	metery	10/5		Hebron,	MD 1 Association		
Physician //Medical //Examiner	dical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):									
the death certific y the attending p	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of d 9 □ Unknown	death 3	Ectopic pregnancy Other (specify)				23d. Date of delivery  Month Day Year		
law requires that has been signed be 2 should be deta	Completed by Ph	Part II. Other significant conditions contrib	1 □ Y 24a. Was autop	23e. Did tobacco use contribute to the cause of deal  1  Yes 2 No 3 Probably 4 Unk  24a. Was an autopsy 24b. Were autopsy findings ava							
VII.c	Certification: To Be Con	Natural 5 Pending 2 Accident investigation	oital: 1	28b. Time of Injury	3 DOA Othe  28c. Injury Work' M 1 Y	4 L Nursing H	1 □ Yes th (Check only on ome 5 □ Resid 28d. Describe h	performed?   Yes 2 No 1 Yes 2 No only one)   Residence 6 Other (Specify)			
ne Hospital o	Medical Cer	29a. Certifier (Check only one)  29a. Certifying Physici 2 Medical Examiner	an: To the best of my kno: On the basis of examina and manner stated.	wledge, death	occurred at the timestigation, in my op	ne, date and place pinion, death occu	, and due to the	cause(s) and mar	nner as stated. nd due to the cause(s)		
To the within		29b. Signature and title of certifier  30. Name and address of person who comp	MD _	23a) (Timo 1		9204		10-1-	(Month, Day, Year) 08		
Stat Registra	e	BENNETT YU MD 131. Date filed (Month Pay, Year) ?	8 32. Ref strar's Signat	166 51	LINE SALIS	sbury i	md, 2	1801			

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Lola P. Matthews 12:27 AM 10-06-2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Salisbury Coastal Hospice at Wicomico the If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 8/16/1911 Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🛛 F Months Days Hours 214-10-9296 97 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Evertines must be notified at 1 XYes 2 No Director Maryland Wicomico Salisbury 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21804 USA 4262 Snow Hill Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 □Yes 2 X No Specify. ģ Specify: white 3 X Widowed 4 □ Divorced permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic access Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coilege (1-4or 5+) sewing seamstress 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Oscar Phillips Roberta Shockley 2 19a. Informant's Name/Relationship (Type. Print)
Sylvia Fields/niece 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4262 Snow Hill Rd., Salisbury, MD 21804 Baltimore, 20b. Place of Disposition (Name of Commetery crematory or other place) WICOMICO MEMORIAL Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/10/08 Salisbury, MD Park 22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 21. Signature of Funeral Service Licenses Steins 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** BNA DAMBATIA STACR disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Box 68760, attending physician Physician/Medical as the t use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes No
9 Unknown Month Year Day 4 Pregnant at time of death 5 Other (specify) P.O. ed by the detached 9 Unknown signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes → No 24a. Was an has page 2 autopsy perform certificate 1 Yes 2 ANO Hospital or Attending Physician; 24 hours after death. Funeral Director; After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Hospice within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral of 28a. Date of Injury (Month, Day, Year) 27. Mapner of Duath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature and little of certifier 29c. License number D0058410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) P.O BOX 1733 nutu State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2008 Year **Physician** October 5, 5:00 a John Michael Pearo /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's 7804 Chapel Cove Drive Laurel 8. Date of Birth (Month, Day, July 27, Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 XM 2 ☐ F Yrs. 1951 Minnesota 57 Director 220-46-6210 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It a Medical Expriser must be now that any injury or other traumatic event, It as New Jical Expriser must be now that any injury or other traumatic event, It as New Jical Expriser must be now that any injury or other traumatic event, It as New Jical Expriser must be now that any injury or other traumatic events. 10d Inside City Limits 10c. City, Town or Location 10a, State 10b. County Laurel 1 ☐ Yes 2 No Prince George's Maryland Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20707 USA 7804 Chapel Cove Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 

Yes 2 
No
If Yes, Give 1971 

1971 

No Street Str 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Year or Dates: 1971-77 Specify. White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Draftsman Architecture 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rosena Nina Rossi James Anthony Pearo မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Road Court Centreville, VA 20120 19a. Informant's Name/Relationship (Type. Print) 5800 Stream Pond Court, Centreville, Anne Pearo/Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition Oct. 1 ☐ Burial 2XXCremation 3 ☐ Removal from State Metropolitan Crematory Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 2008 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. Allisa M Arevalo 500 University Blvd. W., Silver Spring, MD 20901 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** 7 months Cholangiocarcinoma resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical as the l IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy for Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No the detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has performe certificate 1 ☐Yes 2 ☐No 1 ☐ Yes 2 XNo filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🔀 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural М 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

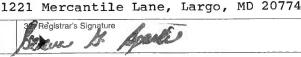
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. within 2. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2008 d26250 October 6, 30. Name and a dress of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

Matilda So, MD
31. Date filed (Month, Day, Year)

OCT 08 2008



Division or Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

completely filled in by the funeral director, within 24 hours after death.

Fo the Funeral Director: After To the Hospital or within 24 hours after

State Registrar

Medical

29a. Certifier (Check only one)	Certifying Phy	sician: To the best of my knowledge, deat iner: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place, and due evestigation, in my opinion, death occurred at the	to the cause(s) and manner as stated. e time, date and place, and due to the cause(s)		
29b. Signature and ti	itle of certifier		29c. License number	29d. Date signed (Month, Day, Year)		
1 8	somy's	S, I. ALIMD	D0046020	10/3/108		
30. Name and address	ss of person who c	ompleted cause of death (item 23a) (Type,	Print)			

Syed Ali, M.D. 505 Dutchman's Lane, Easton, MD 21601

31 Date filed (Month)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Sherwood nde /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner bert ambr 0 0 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Social Security Number **Funeral** Days Hours 1 M 2 □ F Director 216 - 16 - 120 Usual Residence of Decedent -16-10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits items 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. 2 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Worker manu 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 19b. Mailing Address (Street and Number or Rural Poute Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) inder MD216B 100 semai ambridge 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 11/08 ambridge 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Henry Ferneral Home, Pit. 22. Name and Address of Facility (ambridge Washing Jon MID 21613 Approximate Interval Between Onset and Death 23a. Part1 (Finter the disease, or complications that caused the treath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Ctrempy, Burn Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): THERTENSION Examiner YERR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ 1☐Live birth in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 MENTIA 3 Probably 1 ☐ Yes 2 ☐ No 4 Unknown Completed After this certificate has been DIREXI 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe CON GESTILE HOR7 1□ Yes 2 1740 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 1 ☐ Yes 2 No ှင 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident To the Funeral Director: 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

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State Registrar MN, VETOVING

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Registrar's Signatu

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1. Situris-

0 8 2008

**Physician** /Medical Examiner

Baltimore, Maryland 21215-0036

Records, P.O. Box 68760,

Division or Vital

Certificate of Death 2. Date of Death 3. Time of Dieath 1. Decedent's Name (First, Middle, Last) Day **Physician** HAROLD E POWELL October 7 2008 10:00 A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Northampton Manor Health Care Frederick Frederick If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 219-12-2111 June 8 1925 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 X Yes 2 □ No Frederick Walkersville Director Maryland | 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 47 Sherwood Dr. 21793 United States Funeral 14 Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. filed within 72 hours after 1 XYes 2 No If Yes, Give Year or Dates: 1943 -46 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Plumber / Electrician Federal government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; If item 27 is marked oth any Injury or other traumatic event ones. Powe11 Luther **Ellen** Leona ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 47 Sherwood Dr. / Walkersville Thelma Powell / Wife Maryland 21793 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resthaven Mem. Garden 10/11/2008 Frederick Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Stauffer Funeral Home 23a. Parti. E. to he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or lear failure. List only one cause on each line. 40 Fulton Ave. / Walkersville MD Approximate Interval Between Onset and Death Immediat (C) use (Final disease (C) ondition resulting in death) METASTATIC BLADDER CANCER MONTHS Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. But it is a sequence of the cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed burial-trar Due to (or as a consequence of) physician Physician/Medical the as attending nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe 1- Yes 2 No 3 Probably 4 Unknown Completed DIABETES funeral director, pege 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No RENAL INSUFFICIENCY 24a. Was an autopsy certificale 2F No 1□ Yes Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Hospital or Attending 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident death 24 hours after death e Funeral Director: filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Continued in the date in the d 29a. Certifier Medical within 2. To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifi D32171 10/9/08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RICHARD GOUGH PO BOX WALKERSUILLE 21793 31. Date filed (Month, Day, Year) 32. Registrar's Signature State UCI 0 9 200 Registrar

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Voor Lucille Vincess Policicchio 1:45 A October 4 2008 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital <u>Takoma Park</u> Prince Georges Month, Day, Year) Social Security Number 1□M 2X F Months Days Hours 577-30-9389 84 5, 1924 Washington, D.O Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes XX No Maryland Prince Georges Brandywine 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 10505 Cedarville Road Lot-7-1 20613 USA 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black White etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes XX No Specify: White 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sales Associate 12 Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Louis Consorti Theresa Vito Consorti 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) <u> 2236 Harford Court, Waldorf, Maryland, 20602</u> Terry Wright/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 □ Cremation 3 □ Removal from State St. Mary's Cemetery Oct. 9, 2008 Washington, D.C. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signal are of Funeral Service 22. Name and Address of Facility Huntt Funeral Home 101436 3035 Old Washington Rd. Waldorf, MD. 20601 23a. Part1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) per Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) P to (or as a consequence of) iac If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1□ Yes

Physician /Medical Examiner

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certificate has

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After

filled in by the

Medical

e Hospital or Attending Pi 24 hours after death. e Funeral Director; After t

24 hours a

To the Hosp within 24 hou To the Fune completely fi

that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

**Physician** 

Examiner

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

/Medical

Director

Funeral

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Completed

Be 2

Examiner

Physician/Medical the nse signed by the a d be detached f ģ Completed Be 2 Certification:

IF FEMALE 23b. Was decedent pregnant 9 Unknown

	Was case referre	d to medical		26. Place of Death (Check only of e)							
	examiner?	lo	Hospital:	1 Inpatient 2□	ER/Outpatient	3 🔲 [	OOA Other:	4 Nursing	Home	5 ☐ Residence 6 ☐ Other (Specify)	
27.	Manner of Death 1 Natural 2 Accident	5 Pending investigation	1	Date of Injury (Month, Day Year)	28b. Time of Injury	М	28c. Injury a Work? 1 ☐ Ye	t s 2∐No	28d.	Describe how injury occurred	
	3 ☐ Suicide 4 ☐ Homicide	ide 6 ☐ Could not be		Place of injury - At he building, etc. (Specif	ome, farm, stree fy)	treet, factory, office				Location (Street and Number or Rural Route Numb City or Town, State)	

29a. Certifier

29b. Signature and title of certifier

1 Priffying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29c. License number

ed cause of death (Item 23a) (Type, Print

29d. Date signed (Month, Day, Year)

State

Registrar

		1	For State Registrar	State of Marylar		rtment of He tificate of D		ental Hygle <sub>Reg.</sub>	No. 2008	33712	
	Dhusisis		1. Decedent's Name (First, Middle, Last)					Date of Death     Month	Day Year	3. Time of Death	
	Physicia /Medic	al .		OBERTS		4h City Town or I	agation of Death	OCTOBER	15 2008 4c. County of Deatl	7:30 <sup>P M</sup>	
	Examin	er	4a. Facility Name (If not institution, give sta FREDERICK MEMORIA			4b. City, Town, or l		FREDERICK			
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	i	If Under 1 Year   Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth 10-20-19	9. Birtl	nplace (State or Foreign untry) MD	
L	Director		214-10-1404	м 2Ё	Yrs.			10-20-19	14		
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modeal Examinatorial to notified at once.		10a. State 10b. County		ity, Town or Loc					10d. Inside City Limits 1 □Yes 2 🛣 No	
		Director	MD Frederic	ek Fi	rederic			10-	. Citizen of What Co		
	with th		10e. Street and Number 7401 Willow Road			10f. Zip Code 2170	2	Tog	USA	and y :	
	ems 2	Funeral	11. Marital Status	2. Was Decedent Ever in U Armed Forces?	J.S. 13. V	Vas Decedent of His f Yes, specify Cubar	spanic Origin? (Sp. n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White		
36	rs after I", or its	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1  ☐Yes 2 No If Yes, Give Year or Dates:	1	I□Yes 2 <mark>K</mark> No	Specify:		Specify: W	hite	
5-0036	2 hour	ted	15. Decedent's Educa (Specify only highest grade	ation completed)	1 (Give	dent's Usual Occupa kind of work done de	uring most of work	ing 16	b. Kind of Business/	ndustry	
21	rithin 7 ne. <b>han "r</b>	Be Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		00 NOT use retired) Clerk			'ood Servi	ce	
р Б	filed w Hygie other t	ပ္ပ	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle, Ma	iden Surname)		
an	Ald be Alental rked o	70 B	Roy Kidd					Hummer			
Maryland 2121	12 should be fi h and Mental H 7 is marked of traumatic eve		19a. Informant's Name/Relationship (Typ		19b. Mailir	ng Address (Street a	nd Number or Rur	al Route Number, C	City or Town, State, $217$	Zip Code) Z <b>O1</b>	
e, S	1 and Health em 27 ther to		Ronald Young	Son 20b.		sition (Name of natory or other place			c. Location - City or		
E O	Pages 1 nent of h int: If ite iry or of		1X Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)		ount 01	ivet Cem.	10-21		ederick,		
Baltimore,	permit. Departr Importa any Inju		21. Signature of Funeral Service License	an 10117	$6 \qquad \begin{array}{ c c } \hline & & & & \\ 1 & & & \\ \end{array}$	Name and Addres  6 East Ch	s of Facility Ke nurch Str	eney & Ba eet Frede	erick, MD	1. ғ.н. 21701	
			28a. Part Enter the disease, or complic shock, or heart failure. List only one		ath. Do not ent	er the mode of dying	g, such as cardiac	or respiratory arres		Approximate Interval Between Onset and Death	
1	Physician		Immediate Cause (Final disease or condition	Cespi	ratio	n Pn-	ecm.	nia		/ wh	
a Seed	/Medical Examiner		resulting in death)	Due to (or as a conse	quence of):	10	17120 =	0		5 Years	
		ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a conse	quence of):	-N 2	1010- 7	<u> </u>		3 0	
1	ocuted nd transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events cause)							<u> </u>	
68760,	Physician: The law requires that the death certificate be executed r this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	a Ex	resulting in death) Last	Due to (or as a conse	equence or):						
687	ifficate g phys	edical	d.								
Box	ith cert tendin r use a	an/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe	tal death 3	Ectopic pregnancy	,		23d. Date of de Month	Date of delivery Month Day Year	
P.O. E	law requires that the death certifias been signed by the attending 2 should be detached for use as	Physician/M	1 ☐ Yes 2 ☐ Mo 9 ☐ Unknown	4 ☐ Pregnant at time o 9 ☐ Unknown	f death 5 L	Other (specify)					
σ.	s that t ned by		Part II. Other significant conditions con		esulting in the u	nderlying cause give	en in Part I.	23e. Did toba	2.0	o the cause of death?	
ords	equires	ed b	Cormary	artery	914	194		1 ☐ Yes		robably 4 Unknown	
ecc	e law re has be	Completed by						24a. Was an autopsy perform	prior to	utopsy findings available completion of cause of	
alF	sician: The certificate rector, pag		25. Was case referred to medical			_	26 Place of Dea	1 □Yes 2- th (Check only one,	<b>∑N</b> o 1 □ Ye	s 2□No	
Ę	/sicia s certi directo	To Be	eyaminer?	ospital:	☐ ER/Outpatie	nt 3 DOA Othe	or:		ice 6 Other (Sp.	ecify)	
Division of Vital Records,	ng Phy fter thi neral (	D:T	27. Manner of Death  1 ■ Natural 5 □ Pending	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	Worl	ί?	28d. Describe hov	injury occurred		
Sio	Attending or death. ector: After by the fune	icati	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At	home farm st		Yes 2 □ No	28f. Location (Stre	eet and Number or F	Rural Route Number,	
ΟĬ	after of Direct I Dir	Certification:	4 ☐ Homicide determined	building, etc. (Spe	cify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Town,			
	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate hy completely filled in by the funeral director, page	Medical C	29a. Certifier (Check only one)	sician: To the best of my k ner: On the basis of exami and manner stated.	nowledge, dea ination and/or i	th occurred at the tin nvestigation, in my c	me, date and place pinion, death occu	e, and due to the ca cred at the time, da	use(s) and manner at te and place, and du	as stated. e to the cause(s)	
	To the within a To the comple	Mec	29b. Signature and title of certifier			29c. Licens			d. Date signed (Mor		
	,- ,- 0		Custin	Kearr	e	100	0968	7	10/16/	08	
	n		30. Name and address of person who co	mpleted cause of death (It	em 23a) (Type	Print)	t Freder	ick. MD 2	1701		
	St	ate	31. Date filed (Month, Day, Year)	- APP			.c II.Cucl				
	Regist	rar	OCT 2 2 2008	Alleria de	The state of the s	The state of the s					

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician 8:20 A M October 2008 Clyde L. Rupert /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Howard Somerford Place Nursing Home Columbia If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1**X** M 2□ F 190 18 0777 85 07-15-1923 Pennsylvania Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10h. County 28a-f show ed other than "natural", or items 23a or 28a-f shov event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Ellicott City MD Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21043 United States 4713 Wigglesworth Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 27 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify à 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Service Manager 2 should be filed w n and Mental Hygie is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Eleanor Loveland Clyde L. Rupert 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) s 1 and 2 s of Health an item 27 is 4713 Wigglesworth Court Ellicott City, MD 21043 Mary R. Perseghin/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot 1 ☐ Burial 2XI Cremation 3 ☐ Removal from State 10-10-2008 Hanover, MD Ardent Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee M01044 Them Collis-4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Dementia year Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: VA A 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Fibrillation 2MNo 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ▼ No 24a. Was an page 2 autopsy 1□ Yes **2**∤∑ No ector, 26. Place of Death (Check only one) Be 25. Was case referred to medical Other: 4 Nursing Home 5 - Residence 6 - Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA

Division or Vital Records, P.O. Box 68760, or Attending Physician: after death in by t

Medical Certification: To

within 24 hours a

To the Funeral I

completely filled To the Hospitai State Registrar

filled

27. Manner of Death

1X Natural

2 ☐ Accident

3 ☐ Suicide

4 Homicide

(Check only one)

29b. Signature and title of certifier

5 Pending investigation

6 Could not be determined

28a. Date of Injury 28b. Time of (Month, Day Year)

Injury

1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28c. Injury at Work?

28f. Location (Street and Number or Rural Route Number, City or Town, State) [Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28d. Describe how injury occurred

29d. Date signed (Month, Day, Year) October 7, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Harry Li 8600 Snowden River Parkway Suite 301 Columbia, Maryland

31. Date filed (Month, Day, Year) OCT 0 8 2008 32. Registrar's Signature

m. O.

DHMH 17 Fav 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Time of Death October 7 2008 ar **Physician** 2:08 A Shore Nathan Joseph /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Montgomery 6206 East Halbert Road Bethesda Birthplace (State or Foreign Country)
 NY If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 1977) 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** Year) Days Hours Months 83 Yrs. 089-20-5769 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Mudical Exp. in any injury or other traumatic event. 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 XYes 2 □ No Director Bethesda MD Montgomery 10o. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe United States 20817 6206 East Halbert Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 2 🛣 No Specify: <u>ک</u> 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) DC Government 5+ DC Parole Board Member 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Eva Fuchs Morris Shore 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6206 East Halbert Road Bethesda MD 20817 Rita Shore - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
Garden of Remembrance
Memorial Park 20c. Location - City or Town, State 20a, Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 10/8/08 Clarksburg, MD 4 Donation 5 Dother (Specify) 22 Name and Address of Facility
Edward Sagel Funeral Direction Inc
1091 Rockville Pike Rockville MD 20852 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician 3 Weeks disease or condition resulting in death) Metastatic Adenocarcinoma of the lung /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-tra Due to (or as a consequence of) Box 68760 Physician/Medical as attending p IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) Ö 9 Unknown cate has been signed by page 2 should be detach σ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Š 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2【□No 24a. Was an autopsy certificate 2 **X**No 1 ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending 1 ☐Yes 2 ☐No investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Octobver 7, 2008 D17211 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

OCT

08

2008

Kenneth Goldstein MD 5530 Wisconsin Avenue #1125 Chevy Chase MD 20815

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Schwartz 10:03 А.м R. October 2008 1, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Shady Grove Adventist Hospital Rockville 8. Date of Birth (Month, Day, Year) Dec 7,1910 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 □ M 2 🔀 F 218-30-4101 97 Dec. Washington, D.C. Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 28a-f show Examiner: set be notified at Gaithersburg MD Montgomery 1X Yes 2 No Directo the 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ò Pages 1 and 2 should be filed within 72 hours after death with 407 Russell Avenue #210 20877 United States 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married ٩, Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White þ If Yes, Give Year or Dates: 3 ₩ Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) event, the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Clerical permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien important: If Item 27 Is marked other the any Injury or other traumatic event, Itel once. Secretary 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Laura Black Edgar William Rogers မှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 301 Russell Ave., Gaithersburg, MD 20877 Patricia Bosse/ Friend 20b. Place of Disposition (Name of cemetery, crematory, or other place)
Geo. Wash. University

Color 5 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Geo. Washington, D.C. 4 ☐ Donation 5 ☐ Other (Specify) 2008 Medical Center Signature of Funeral Service Licensee 22. Name and Address of Facility Columbia Mortuary Services, P.A. 9013 Annapolis Road Lanham, MD 20706 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician eck pheumor resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Year Month Day 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has be rector, page 2 s performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check onl one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ■ Inpatient 2 □ ER/Outpatient 3 □ DOA မှ this within 24 hours after death.

To the Funeral Director: After th
completely filled in by the funeral. 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 ☑ Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) ical 29a. Certifier Medi and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of confifer 30. Name and address of person who completed cause of death (Item 23a) (Type, Print

State Registrar 31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 A Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year MARGARE T, 2045 PM SMITH C Oi 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** DRIHESTER DOFCHESTER CAMBRIDGE GENERAZ HEZSPITAL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Months Days 24-0090 1 □ M 2 🛛 F Director Oct. 10. Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Experient sust be recipied at 1XYes 2 No Funeral Director 10g. Citizen of What Country? 10e. Street and Number axMore Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married ☐Yes 2 No 21215-0036 1 ☐Yes 2 XNo If Yes, Give Year or Dates: Specify þ 3 ₩ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Worker macessina Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 12 should be fill h and Mental H Mortiner namie ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 t of Health cretta Lane Cambridge, Department of Heal Important: If item 2 any injury or other once. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Cemetery 4 ☐ Donation 5 ☐ Other (Specify) permit. 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Henry Funeral Home, P.A. 510 Washington Str Cambridge, 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) TRACT RINARY **Physician** INEERTION /Medical Due to (or as a consequence of) Examiner PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): the attending physician Division of Vital Records, P.O. Box 68760, Physician/Medical as the l IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2 No 9 Dunknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Unknown Completed POOR NUTRITIONAZ 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA After this Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after deatl To the Funeral Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 2/08 52/4

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State Registrar

Registrar
DHMH 17 Rev 1/2001

Abul Foyez Arifuddowla, M.D.,
31. Date filed (Month, Day, Year)
32. Sistrar's Signature of the Control of the C

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

, M.D., 219 S. Washington St., Easton, MD 21601

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Division of Vital Records, P.O. Box 68760,	Hospital or Attending Physician: The law requires that the death certificate be executed hours after death.
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/Medic Examin		4a. Facility Name (If not institution, g	ive street and numb	er)		4b. City, Town, or	Location of Death		4c. County of Deat	h
<i></i>	Ŭ.	FREDERICK MEMOR	RIAL HOSP	ITAL		FREDER	ICK		FREDER	ICK
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s afte	by F	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	1 ∐Yes 2 If Yes, Give Year or Date		1	I∐Yes 2∏No	Specify:		Specify: Wh	nite
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alth a		Peggy Shaver /	Daughter		56	30 Mounty	ville Rd.	. Adamst	own, MD 21	710
of He item		20a. Method of Disposition	U	00	ace of Dispos	sition (Name of natory or other plac	i	Date	20c. Location - City or	Town, State
Page nent int: If		1 ☐ MBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec		Mt.	01ive	t Cemeter	y 10/8	/2008	Frederick	, Maryland
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentall Hygiene. Important: If time 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner mast be notified at once.		21. Signature of Funeral Service Lice	ensee	, ,	22	. Name and Addres	ss of Facility	Stauffer	Funeral H	
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To the withing the company of the co	M	29b. Signature and title of certifier		10		29c. Licens	e number 06462		29d. Date signed (Monitor) 10/5/2002	
(9)		30. Name and address of person wh	o completed cause	of death (Item	23a) (Type,	Print)				
(0)		Sandeep Sharma	a, MD 40	00 W. 7	7th St	reet, Fre	derick,	MD 21701		
Sta	te	31. Date filed (Month, Day, Year)	32. Reg	jistrar's Signat	ture					
Registr	ar	OCT 0	9 2008	Page 12	B. 1	Sparke				
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			Registrar  1. Decedent's Name (First, Middle, Las	<i>t</i> }			inical	COIL	Jean		2. Date of De	Reg. No.	200	3 Time	of Death
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Ŧ	Funeral		5. Social Security Number 6. S	ex	7. Age (In yrs.	last birthday)		r 1 Year	if Under	24 Hrs.	8. Date of Bir	th	9. B	rthplace (Sta	te or Foreign
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2-003p	d within 72 hours after death with the Maryland giene. rr than "natural", or Items 23a or 23a-f show the Medical Examiner must be notified at	bed	15. Decedent's Ed	ucation		16a. Dece	dent's Usu	al Occupa	ation			16b. Ki	nd of Busines	s/Industry	
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0 0	ding Ph		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date (Mor	of Injury oth, Day Year)	28b. Time o Injury		28c. Injun Work	y at </td <td>2</td> <td>28d. Describe</td> <td>how injur</td> <td>y occurred</td> <td></td> <td></td>	2	28d. Describe	how injur	y occurred		
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UIVISION	or At ifter d Direct in by	Certification:	4 Homicide determined	28e. Place	e of injury - At he ling, etc. <i>(Specil</i>		reet, tactor	у, опісе		2	28f. Location ( City or To	Street an wn, State	d Number or	Hurai Houte f	Number,
_	ppital Durs a peral   filled		29a. Certifier 1 Certifying Ph	vsician: To the	e best of my kno	owledge, deat	th occurred	d at the tin	ne, date a	nd place.	and due to the	cause(s	and manner	as stated.	
	24 hose Fur	Medical	(Check only 2 Medical Exar	niner: On the I											se(s)
	To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Me	29b. Signature and title deartifier	10			1	c. License					te signed (Mo	nth, Day, Yea	r)
)			1// Ar	Herk			(	2100	102	768	>	10	17/0	8 -	
	2		30. Name and address of person who	ompleted cau	se eraleath (Iter	n 23a) (Type,	Print)		111		ncl.	_	1-1-		
	$\sim$		III W. High	Stre	eet 5	UI te	104	E	Ktor	1, 1	ncl.	219	21		
	Sta Registr		31. Date filed (Month, Day, Year) OCT 9: 8 20	08 /	Registrar's Signa	k do	we								

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Year Month **Physician** 100 PM 10 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Worcester Berlin nursing home Berlin If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. May 14 Day. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** 1 □ M 2 🕇 F Norway 87 076-16-8695 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County or 28a-f show the Medical Examiner must be notified at 1 □Yes 🎗 💢 No Director Berlin Maryland | Worcester 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21811 27 Pinehurst road items 23a Funeral Pages 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23 ury or other traumatic event, the Medical Expriner must Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Steele, Aase Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2X ☐ No Specify: White Specify: Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) home homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Linka Beck Sigvart Ingebrigtsen ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health au
Important: If item 27 is
any injury or other trau 27 Pinehurst road Berlin, MD 21811 George Ingebrigtsen-brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Oct. 8, 2008 Frankford, DE Cape Henelope 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service I 22. Name and Address of Facility Burbage Funeral Home 108 William street Berlin, MD 21811 23a. Part J. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** EMENTIA /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Year Month Day 5 Other (specify) 1 ☐ Yes 2√ ☐ No P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. <u>Ş</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy 2 No 1 ☐ Yes 2 DINO 1 ☐ Yes ours after death.

eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BA5 EXTERN SHIRE DR, SALISBURY MD21804 614 B Registrar's Signature 31. Date filed (Month, Day, State 0 8 2008 Registrar

DHMH 17 Rev 1/2001

			1- State of Maryland / Depa Cer	rtment of Health and N tificate of Death	fental Hygie Reg.	
			Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
	Physicia /Medic		Betty Tennesen		October	16, 2008 4:11 PM
	Examin		4a. Facility Name (IF not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
			835 Back River Neck Road	Essex		Baltimore
	Funeral Director		5. Social Security Number 6. Sex 1 1 M 2 F 7. Age (In yrs. last birthday) 4. Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye 04/21/19	9. Birthplace (State or Foreign Country) MaryLand
	pu k		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Loc	cation		10d. Inside City Limits
	Aaryle sho	ō				1 ☐ Yes 2 ☐ No
	288-1	Director	MD Harford Havre de	10f. Zip Code	10g.	. Citizen of What Country?
	3a or		404 S. Juniata Street	21078		u.s.A.
	ms 2	Funerai	11 Marital Status 12. Was Decedent Ever in U.S. 13. V	Vas Decedent of Hispanic Origin? (Sp Yes, specify Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - American Indian, Black, White, etc.
5-0036	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or Items 23e or 28e-f show event, I'n Medical Exertinal retails a routiled at	þ	1 Never Married 2X Married 1 ☐ Yes 2 X No	Yes 2 No Specify:	Hican, etc.)	Specify: White
בְּ	72 ho	Completed	15. Decedent's Education 16a. Deced (Specify only highest grade completed) (Give	lent's Usual Occupation kind of work done during most of work	sing 161	b. Kind of Business/Industry
7	within 72 ene. than "nat	nple	Elementary/Secondary (0-12) College (1-4or 5+)	OO NOT use retired)		0
7	filed w Hygier other th	Co		ales	e (First, Middle, Mai	Cemetery
ב		Be	17. Father's Name (First, Middle, Last) Roy Herbert		ia E. Hall	1
Maryland	s fand 2 should b f Health and Ment itam 27 Is marked other traumatic e	은		g Address (Street and Number or Ru		
<u>s</u>	D & M 2		200	. Juniata St Ho	C 20 1080	1905 - V003103-085T
<u>6</u>	s far f Hea itam otha		20a Method of Disposition 20b, Place of Disposi	sition (Name of natory or other place)		c. Location - City or Town, State
Ë	Pages nent of I int: If it				20/2008 A	berdeen, Maryland
Baltimore,	permit. Pages 1 an Department of Heal Important: If itam 2 any injury or other once.			Name and Address of Facility ZC. 23 S. Washington		ral Home, P.A. Le de Grace, MD 21078
		-	23a Part 1. Enter the disease, or complications that caused the death. Do not ent			
d	Pnysician		shock, or heart failure. List only one ause on e of line. Immediate Cause (Final	Anroh		Onset and Death
	/Medical		disease or condition resulting in death)  Due to r as a consequence of):	ances		
	Examiner		Sequentially list conditions			
	p #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
22	ecute and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):			
8/60,	cate be executed physician and the burial-transit	ai E	Due to (or as a consequence of).			
287	P de ta	dicai	d			
ROX	it the death certifi by the attending tached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delivery
ň	death e atte	icia	in the past 12 months?  1 Ves 2 May 4 Pregnant at time of death 5	Ect <i>o</i> pic pregnancy  Other (specify)		Month Day Year
j	tt the by the tache	hys	9 Unknown			
ecords, t	The law requires that the death certifi tte has been signed by the attending page 2 should be detached for use as	þ	Part II. Dther significant conditions contributing to death but not resulting in the un	nderlying cause given in Part I.		cco use contribute to the cause of death?  2 No 3 Probably 4 Inknown
O O	aw require s been siy	Completed			24a. Was an	24b. Were autopsy findings available prior to completion of cause of
ľ	The law	mo			autopsy performe 1 ☐ Yes 2 ☐	d? death?
Vital		BeC	25. Was case referred to medical	26. Place of Dea	th (Check only one)	
o   	Phyaician: r this certifica ral director, p	To	examiner?  1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatien		ome 5□ Residend	ce 6 X ther (Specify)
<u>د</u> 0	ding Pl h. After ti funera	on:	27. Manner of Death 28a. Date of Injury 28b. Time of Injury (Month, Day Year) Injury	Work?	28d. Describe how	injury occurred
<u>s</u>	Attendi death. ctor: A y the fu	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 28e Place of Injury At home form str	M 1 Yes 2 No	OR Leasting /Ctro	et and Number or Rural Route Number,
Division	l or Attend after death Diractor:	Certification:	determined  4 Homicide  determined  4 Homicide  determined  determined  28e. Place of Injury - At home, farm, str	eet, factory, office	City or Town, S	
_	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical C	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death (Check only one)	n occurred at the time, date and place vestigation, in my opinion, death occu	, and due to the caus rred at the time, date	se(s) and manner as stated.  o and place, and due to the cause(s)
	o tha ithin 2 o tha xmple	Med	one) and manner stated.  29b. Signature and title of certifier	29c. License number	29d	I. Date signed (Month, Day, Year)
	βÃξ		Markey Maila M	X CIMES	0	10-17-08
	n		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)	•	IN / VO
	3		4701 Ogletoun Stanton Ro	1 Newark D	6 19713	3
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature			
	Registi	ar	OCT 2 2 2008 Regard & Soule	7		

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) <sup>Mgn</sup>† 28/08 ROSALIE OLIVER TINNEY 1:00 AM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Arcola Health & Rehabilitation 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday, Silver If Under 1 Year Spring If Under 24 Hr 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days 1 ☐ M 2 💢 F 95 Months Hours Min 047-16-1870 8/23/13 Pine Bluff, Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State MDMontgomery Silver Spring 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 321 University Blvd., West 20901 Montgomery 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify Specify: 3**X**XVidowed 4 ☐ Divorced Black 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Industry Dietition 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Oliver Bertha Thomas 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Samuel Hoston/Son 11410 Fair Oak Dr., Silver Spring, MD 20902 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place; 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Pine Grove Cemetery 10/10/08 Ansonia, Conn. 21. Signature of Funeral Service Licensee 22. Name and Address of FacilitAustin Royster Funeral Home 3821 - 14th Street, N.W., Wash., DC 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Senile Debility disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Usease or injury that initiated events Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month Day Year 4⊡Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hypertension 1 Yes 2 No 3 Probably 4 Unknown Stroke 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy Heart Disease 1∏ Yes 2 **X**No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 2 ER/Outpatient 3 DOA 1 Inpatient 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred

Physician /Medical **Examiner** 

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After

To the Hospital or within 24 hours after death.

To the Funeral Director: Aft

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Completed page 2 should

Be

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Certification:

Medical

physician s the burial

and

certificate be executed

requires that the death

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Box

P.O.

Division or Vital Records,

**Physician** 

/Medical

Examiner

Director

by Funeral

Completed

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**Funeral** 

Director

show

?7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

within 72 hours after

2 should be f and Mental H

permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other trau

Baltimore, Maryland 21215-0036

Examine resulting in death) Last Physician/Medical

IF FEMALE: 23b. Was decedent pregnant

1 Yes 2 No 27. Manner of Death 2 Accident

5 ☐ Pending investigation 6 Could not be determined

1 □ Yes 2 □ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

28f. Location (Street and Number or Rural Route Number, City or Town, State)

10/7/08

29a. Certifier (Check only one)

3 ☐ Suicide

4 ☐ Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

29b. Signature and title of certifier

D56691

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (flem 23a) (Type, Print) Ghousia Sultana,

12107 Heritage Park Circle Silver Spring, Maryland 20906

State Registrar 31. Date filed (Month, Day, Year OCT



and manner stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death TRACY Month 2008 **Physician** KENNETH LEON 3:00PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Springs SUBURBAN porter Silver HOSPINAL Montgomer If Under 24 Hgs. If Under 1 Year 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F Months 578-28-9464 Days Director Usual Residence of Deceden permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" -- any injury or other traumatic event. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State Y Yes 2 No KENNSIN GTON **Funeral Director** MD MONTGOMERY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20895 USA 410 CVS 12. Was Decedent Eyer in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 No Specify Specify: BLACK 2 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) OF ROCKVILLE Elementary/Secondary (0-12) College (1-4or 5+) SANITATION DEAR 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be WILLIAMS JAKE IRAC SADIE 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2061 ( 19a. Informant's Name/Relationship (Type. Print) Rd Apt 201 KENSINGTON MA LERA 4107 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Methed of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State SATES OF HEAUDY COM, Uct 9 2008 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility GARY L. ROLLING FUN. 1 Home 21. Signature of Funeral Service Licensee Kur of 2170 MD Febberica 110 WOST SOUTH ST 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or higher failure. List only one cause on each line. Approximate Interval Between Onset and Death UNICOUN Immediate Cau (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) PNEUMONIA Examiner SAIRATTON UN KNOW N Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner DIABUTES UNKNOW N attending physician and for use as the burial-tran Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Month Year 5 Other (specify) Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Vital To the Hospital or Attending Physician: "within 24 hours after death." To the Funeral Director: After this certifications are properties of the Funeral Director. 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1. Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending 1 □Yes 2 □ No investigation 2 ☐ Accident ☐ Could not be Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Deme 25 d DO062955 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rochville, Md. 20852 omNez 11119 Lackville Tille etek

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

OCT 0 8 2008

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amended#26perMD FCHD, KS Certificate of Death 10/9/08 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Gilbert Wilmer Toth October 2008 5:40 P M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Memorial Hospital Frederick Frederick If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 11, 1 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. Months 1 X M 2 □ F 1953 Maryland Director 55 216-60-1271 Usual Residence of Deceden 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a State 10b. County ral", or items 23a or 28a-f show 1 ☐Yes 2 1xt No Director Frederick Mt. Airy Maryland 10g. Citizen of What Country? 10f Zin Code 10e. Street and Number death with United States 21771 5636 Catoctin Ridge Road Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? 1 □Yes 2 ဩNo Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Yes 2 1 If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☑ No Specify <u>م</u> 3 Widowed 4 Divorced 'natural' Completed 7 is marked other than "natur traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Computer Programer/Analyst 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rosanna Hagel ပ္ Joseph Ralph Toth 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health a 5636 Catoctin Ridge Road Mt. Airy, Maryland 21771 Jill C. Williams / Wife Item 27 other to 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State ō permit. Page Department of Important: If any Injury or once. 10, 2008 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Crematory Frederick, Maryland 22. Name and Address of Facility Stauffer Funeral Homes, P.A. Mt. Airy, Maryland 21771 Ridgeville Blvd. Ε. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Ye ar 5 ☐ Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only on ) Other: 4 Nursing Home 1∐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of After t 1 Natural 2 ☐ Accident 5 Pending Injury s after death. 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide filled in within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) To the 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Yea

Year)

0 9 2008

DHMH 17 Rev 1/2001

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32. Registrar's Signature

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

			for State of Ma	aryland / Depa <i>Cer</i>	artment of F rtificate of I			jiene <sub>leg. No.</sub> 2	8 33725
	Physici		1. Decedent's Name (First, Middle, Last)  Glenn Mitchell	Tyndall			2. Date of Dea		3. Time of Death 1430 M
de .	/Medid Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	r Location of Death	Octi	4c. County of D	eath
	Funeral Director			e (In yrs. last birthday) 51 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day	9, 8	Birthplace (State or Foreign Country) laryland
	yland now		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Loc	cation				10d. Inside City Limits
	he Mar	Director	Maryland Wicomico  10e. Street and Number	Salisbury					1 ☑ Yes 2 ☐ No
	th with t		27322 Musket Drive		10f. Zip Code 21801		1	0g. Citizen of What USA	Country?
36	be filed within 72 hours after death with the Maryland ntal Hygiene.  d other than "natural", or items 23a or 28a-f show event, the Modical Examirer must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  1 Never Married 3 Married  1 Never Married 2 Married  1 Never Married 3 Married  1 Never Married 3 Married  1 Never Married 4 M	4o	Was Decedent of H f Yes, specify Cuba I □Yes 2 XNo	Ispanic Origin? (S an, Mexican, Puerto Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Al Black, Wi Specify:	merican Indian, hite, etc. white
1215-0036	72 hou "natura dical E		15. Decedent's Education (Specify only highest grade completed)	16a, Deced	dent's Usual Occup kind of work done o	ation during most of work	king	16b. Kind of Busines	
212	filed within Hygiene. vther than snt, the Mis	Completed	Elementary/Secondary (0-12) College (1-4or 5-	+)	d Inspect			Cable Cor	mpany
and		To Be (	17. Father's Name (First, Middle, Last)  Ernest M. Tyndall				ne (First, Middle, I Mitchel	Maiden Surname)	
Š	har har 7 is trau	F	19a. Informant's Name/Relationship (Type. Print) Ann Tyndall/wife					r, City or Town, State	
ore C	S to E is		20a. Method of Disposition  1 IX Burial 2 ☐ Cremation 3 ☐ Removal from State	20b. Place of Dispos	sition (Name of natory or other plac			20c. Location - City	or Town, State
altin	permit. Page Department Important: It any Injury o		4 □ Docation 5 □ Other (Specify)  21 Suparture of Europa Service Licensee	Parsons C	. Name and Addres	10/9, ss of Facility	·	Salisbury	
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_	sit ad	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events c.	a consequence of):					<u> </u>
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×	attending for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome 1 □ Live birth 1 □ Live birth 2 □ No 9 □ Unknown	2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)	у		23d. Date of o	delivery Day Year
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VISION OF	tth. :: After e funera	ation:	27. Manner of Death  1 Natural 5 Pending (Month, Day) 2 Accident investigation	(Year) 28b. Time of Injury	28c. Injury Work M 1 🗆	yat :? Yes 2 □ No	28d. Describe ho	w injury occurred	
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)	10xx	-	30. Name and address of person who completed cause of de	eath (Item 23a) (Type F	Print)	)9044	9	10/06	12008
	0 20		Palan 1911 - 1 2220 10	D. E. CARROL		Alis bur	y Md.	21801	
	Sta Registra	te ar	31. Date filed (Month, Day, Year) 32. gistra	r's Signature	meth o				

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day **Physician** Mary Elizabeth Uppercue 3:10 P October 15 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Frederick Memorial Hospital Frederick Frederick 8. Date of Birth Month, Day Yea 12-5-1967 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral 1 □ M 2 🛣 Months Days Hours Min. 40 MD Director 218-94-8509 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28s-f show any injury or other traumatic event, the Medical Exeminations to a chillified a once. 1 □Yes 2 □No Director Frederick MD Thurmont death with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21788 USA 108 Boundary Ave Apt 16 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify \$ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Disabled Unemployed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lonny Shaffer Brenda Morris ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 108 Boundary Ave Apt 16 Thurmont MD 21788 Brenda Morris Mother 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Smithsburg Crematory 10-17-2008 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg, MD 21. Signature of Funeral Service 22. Name and Address of Facility Keeney & Basford P.A. F.H. M01176 ua 106 East Church St Frederick, MD 21701 a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Sepsis **Physician** Days disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 1 Yes 2 No 3 Probably 4 Unknown icate has been si , page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Vas 2 No 1 ☐Yes 2 ☐No 1 ☐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending thours after death. Uneral Director: Aft oly filled in by the fur investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral I

completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number MD 51610 108 15 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD Fre ales, re 21707 a New 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

# ■ Baltimore, Maryland 21215-0036

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Division of Vital Records, P.O. Box 68760,	e law requires that the death certificate be	has been signed by the attending physicie e.2 should be detached for use as the bur
Division of Vital F	o the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.	o the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last, 3. Time of Death 2. Date of Death CTUPER Year **Physician** Weiss 2008 Deborah Ann /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore City Baltimore Months Days Hours Min. Dec. 31, 9. Birthplace (State or Foreign Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🕱 F 39 Vermont 153-64-8015 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Mydical Examination on the natified at once. 1 ☐ Yes 2 🛛 No Director Maryland Charles Waldorf 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20603 U.S.A. 5016 Angel Fish Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☒No If Yes, Give Ye ar or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 M Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: Specify: 3 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Medical Paramedic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Barbara Bagley Tommy Ray Beaittie 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5016 Angel Fish Court, Waldorf, Maryland, 20603 Adam Weiss/Spouse 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 🖔 Cremation 3 ☐ Removal from State Huntt Crematory 10/06/2008 Waldorf, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 3035 Old Washington Road 22. Name and Address of Facility 156Huntt Funeral Home Waldorf, Maryland, 20601 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Onset and Deat ng, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Exami burial-transi Due to (or as a consequence of): attending physician for use as the burial Physician: The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 1% months? 3 Ectopic pregnancy signed by the atte Month Year 1 ☐ Yes 2 No 9 ☐ Unknown 5 Other (specify) Ö σ. significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u></u> 3 Probably 4 Unknown 2 No 1 ☐ Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe 1 □Yes 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 ☐ Yes 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature

Registrar

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Lewis Watson 4, 2008 7:11 October а /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 209 Reservoir Road Perryville If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Months 1₩ M 2□ F 222-14-8658 Yrs. 82 July 11, Delaware 1926 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 28a-f show 1 ☐ Yes 2 No notified Director Maryland Cecil Perryville with the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number r than "natural", or items 23a or the Medical Examiner must be 209 Reservoir Road 21903 U.S.A. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 X Yes 2 No If Yes, Give Year or Dates: 1944-46 1 Never Married 2 Married 5-0036 1 ☐ Yes 2 ☑ No Specify þ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Wiley Manfacturing Co. 2121 College (1-4or 5+) Elementary/Secondary (0-12) Port Deposit, Maryland Twelve Years Steelworker n and Mental Hygir 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maryland 1 and 2 should be Andrew Watson Effie Mae Seeger traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health at Important: If Item 27 Is any Injury or other trauonce. Georgia Watson 209 Reservoir Road, Perryville, Maryland 21903 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages ' 1 ☐ Burial 2XI Cremation 3 ☐ Removal from State R.A. Ferris & Co., Inc. 10/06/08 4 ☐ Donation 5 ☐ Other (Specify) West Chester, Pennsylvania 21. Signature of Funeral Service Licensee Lee A. Patterson & Son Funeral Home, P.A. Chomes M. Jallings Perryville, Maryland 21903-0766 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlying Due to (or as a consequence of) Examine Cause (Disease or injury that initiated events resulting in death) Last executed burial-trar Due to (or as a consequence of) Box 68760. attending physician law requires that the death certificate be Physician/Medical the as nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. the 9□Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of page 2 s certificate has autopsy performe 1 Yes 2 No Physiclan; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 25 NO 1 Inpatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

Records, Division or Vital ne Hospital or Attending P in 24 hours after death. he Funeral Director: After t To the I within 2.

THVA

State Registrar 31. Date filed (Month, Day, Year)

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29b. Signature and title of certifier

111 am 32. Registrar's Signature

36. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		-	For State Registrar	State of Ma	iryiana	•		of Death		Citarriy	Reg. No.	2008	33730
	Physicia	an	1. Decedent's Name (First, Middle, Las	et)			-			2. Date of Do Month	eath Day	Year	3. Time of Death
Shareh	/Medic	al		Harriet Lee	Yaffe	<u> </u>	41 OH T			October	06	2008 County of Death	9:20 a M
	Examin	er	4a. Facility Name (If not institution, give				4b. City, rov	n, or Location			40.0		
	Funeral	str.	Manor Care P  5. Social Security Number 6. Security		(In yrs. las	st birthday)		Potoma ear If Under	24 Hrs.	8. Date of Bi	rth ,	9. Birthp	gomery place (State or Foreign
á	Funeral Director		220-20-2211	□M 2⊠F	76	Yrs.	Months D	ays Hours	Min.	(Month, D March ]		2 Coui	ntry) laryland
	and ww	1	Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Loc	cation					1	10d. Inside City Limits
	Maryl f sho	to	Maryland Montg	omerv				Potomac					1 ☐ Yes 2 K No
	r 28a	Director	10e. Street and Number				10f. Zip Co	de			10g. Citiz	en of What Cour	ntry?
	th wit		107 <b>1</b> 8 Potoma	c Tennis Lan	e			20854				U.S.A	
	r dea tems er mu	Funeral	11. Marital Status	12. Was Decedent 8 Armed Forces?		13. V	Vas Deceden Yes, specify	of Hispanic Or Cuban, Mexica	rigin? (Spe ın, Puerto l	cify Yes or N Rican, etc.)	0- 1	<ol> <li>Race - Americ Black, White,</li> </ol>	
326	I be filed within 72 hours after death with the Maryland ntal Hyglene. ed other than "natural", or Items 23a or 28a-f show e event, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 ☐ Married 3 🔀 Widowed 4 ☐ Divorced	1 □ Yes 2 🔣 N If Yes, Give Year or Dates:	lo	1	□Yes 2【X	No Specify	:			Specify: C	aucasian
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Z Z	id 2 should th and Men 27 is marke traumatic	۵	19a. Informant's Name/Relationship (			19b. Mailin	g Address (S	reet and Numb	er or Rura			Town, State, Zip	p Code)
	1 and 2 Health a em 27 is other trau		Eric Yaffe - S	on		5 G	rove Po	nt Court	, Rock	ville,	Marylan	nd 20854	
ore,	es 1 and of Healt fitem 2 r other	I	20a. Method of Disposition  1 🖾 Burial 2 🔾 Cremation 3 🖾	Romaval from State	20b. Pla	ce of Disponentery, cren	sition (Name natory or othe	of r place)	D	ate	20c. Loc	ation - City or To	own, State
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Baltimore,	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Arvice Licer	vee him		Hi	nes-Rina	ddress of Facil 11di Fune Hampshir	ral Ho	ome, Inc	ver Spi	ring. Mar	yland 20904
			23a. Part1. Enter the dise st, or com shock, or heart failure. List only	plications that caused	the death.	_							Approximate Interval Between
	Physician <sup>®</sup>	i ji	Immediate Cause (Final disease or condition		vanc	TV		nent				1	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as			1001	Te III	~ ,				
	LXammer	-	Sequentially list conditions,	b. Due to (or as	a conseque	ence of):							
2	nted nsit	Examiner	Sequentially list conditions, if any, leading to immediate case. End of Joseph Cause (Disease or injury	500 10 (01 00	a oonooque	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,							
er O	execu in and ial-tra	Exa	that initiated events resulting in death) Last	Due to (or as	a conseque	ence of):							
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_			IF FEMALE:	OOs If was suiteems	-f pro-non	01/							
P.O. Box	The law requires that the death cert ate has been signed by the attending agge 2 should be detached for use	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1□Live birth 4□Pregnent et	2 Fetal o	death 3	Ectopic preg Other (spec				2	3d. Date of deliv Month	Day Year
o.	the de	ysic	1 ☐ Yes 2 ♣ No 9 ☐ Unknown	9□Unknown	time or det		Journal (apoco.						
ď.	n requires that the de been signed by the should be detached	by Pr	Part II. Other significant conditions	contributing to death be	ut not result	ting in the u	nderlying caus	e given in Part	l.	23e. Did	tobacco us	se contribute to	the cause of death?
Vital Records,	equire:							19.1		1 🗆	Yes 2	No 3 □ Pro	bably 4. Unknown
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<u> </u>	The ate h	Com								per 1□ Yes	formed? 2 No	death? 1 □ Yes	2.2No
/ita	rstcian: The law s certificate has b lirector, page 2 s	Be (	25. Was case referred to medical examiner?	Hospital:					e of Death	(Check only	one)		
	Phys r this ral dir	. To	1 ☐ Yes 2 No 27. Manner of Death	1 ☐ Inpatie		R/Outpatien 28b. Time of	t 3 DOA			me 5 ☐ Re 28d. Describe		Other (Speci	ify)
Division or	ling After fune	Certification:	1 Natural 5 Pending 2 Accident investigation	(Month, Da		Injury	м	Injury at Work? 1 ☐ Yes 2 ☐		EGG. BOSONIB	, now injury	00001100	
N S	or Attencater death Director: in by the	ifica	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of inju-	ury - At hon	ne, farm, str	eet, factory, c	ffice		28f. Location	(Street and	d Number or Rui	ral Route Number,
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	To the Hospital or All within 24 hours after of the Funeral Direct completely filled in by	Medical		nysician: To the best niner: On the basis o and manner sta	f examination								
	withir comp	Me	29b. Signature and title of certifier	1				icense number			29d. Date	e signed (Month	, Day, Year)
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			30. Name and address of person who						~ n				
5-	Sta	to	Sunitha Bho (31. Date filed (Month, Day, Year)	35 Registr	ar's Signatu	orgia	HALVIN	# 143	+, Sil	verspri	ind	(ND20	907,
	Registi		OCT 08 20	3 Registr	K	And	all D						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Dav Year Dana Andrews 750 PM 200 /Medical 20 4a. Facilify Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death UMMS Baltimore 8. Date of Birth \_\_\_\_\_ (Month, Day, Social Security Number If Under 1 Year | If Under 24 Hrs. **Funeral** 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1**X**M 2□F Months Hours <u>214-58-633 2</u> Usual Residence of Decedent 20 Days Yrs Director the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Director 1 es 2 No timore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ 1 ☐Yes 2 No Specify. 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry onday (0-12) College (1-4or 5+) 17. Father 18. Mother's Name (First, Middle, Maiden Surname) Be 19b. Mailing Address (Street and Number or Rural oute Number, City or Town, State, Zip Code) 312 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death g, such as cardiac or respiratory arrest, Immediate Cause (Final Physician Gram ne ative rod sersis disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner negtive Se pentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 101 DAEUMONL Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown has been signed by the a 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate ha autopsy performed 2 No 1 ☐Yes 2 ☑No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

Baltimore

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3 2008

2

32. Registrar's Signature

ittan

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-07908 State of Maryland / Department of Health and Mental Hygiene UNK UNK Certificate of Death 1. For State Reg. No Registrar 2. Date of Death cedent's Name (First, Middle,Last) Physician/ Month Day October 20, 2008 2200 hrs Medical Examiner Iremair 4c. County of Death City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Baltimore University Hosptial If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9: Birthplace (State or 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Hours Months Days Country) Director 29 216-94-2764 1 LM 2 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location Inv 10a. State 10b. County 1 Lifes 2 s 23a or 28a-f show e notified at once. hours after death with the Maryland rector 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number 21218 ō 000 Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Was Decedent Ever in U.S. Funeral 11. Marital Status White; etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or items Examiner must be Armed Forces? 1 Wever Married Yes Yes '2 CHO specify. Specify: f Yes, Give Year Divorced Widowed þ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industr 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) Pages 1 and 2 should be filed within 72 in nent of Health and Mental Hygiene 2th marked other than MD 21215-0036 17. Father's Name (First, Middle, Last) (Street and Number or Rural Route Number, City or Town, State, Zip Code) 's Name/Relationship (Type, Print) altimore, MD 606 Old York If item 27 is 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Baltimore, crematory or other place) Burial 2 Cremation 3 Baltimore 10-28.2008 Important: injury or otl Donation 5 Other Specify Vaughin Green Foreral Services 21. Signature of Funeral Service License Baltimore leno aug 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arresi, shock, or heart Between Onset and **Physician** failure. List only one cause on each line Death Medical a. Gunshot wounds (2) of head and torso Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and transit requires that the death certificate be executed Physician/Medical AMENDED attending physician for use as the burial -UNPENDED 23d. Date of delivery Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE: Year Day 3 Ectopic pregnancy 23b. Was decedent pregnant in the Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. Yes 2 ✔ No 3 Probably 4 Unknown þ 24b. Were autopsy findings available Completed 24a. Was an prior to completion of cause of autopsy performed? death? has Yes 2 1 🗸 Yes After this certificate 26.Place of Death (Check only one) 25. Was case referred to medical Physician: Division of Vital Be Residence 6 Other examiner? Hospital: 1 ✓ Inpatient 2 DOA Nursing Home 5 ER/Outpatient 3 2 1 ✔ Yes 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) Oct 20, 2008 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Subject shot To the Hospital or Attending I within 24 hours after death. Certification: 2130 hrs Yes 2 ✔ No Natural Pending Director: Accident Investigation 2 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be 3 or Town, State) 500 Block West Preston Street, Baltimore, MD Suicide determined (Specify) Local Street 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier October 21, 2008 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Ling Li, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 93 Registrar

Carlton Tremain Bethea

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Physician 07:55 AM K. October ,2008 Jan /Medical 4c. County of Dea 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Hospital ot Baltimore Bult more 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number W/K 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F MI Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygleine. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Formarians. 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 Yes 2 No Baltimore MD Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Penhurst Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2. No Specify. Specify: Plack ş 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Infant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ricardo Scott (Horia G. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Gloria G. Briggs 39136 Penhurst Avenue Baltimore MD 21215 Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee C Greene Funoral SVCS Kandallstown MD 21133 1ain Road 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 4 no oths Chirth **Physician** /Medical Due to (or as a consequence of) Examiner Chronic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 □ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0056769 19,2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mospitalot Sinai 31. Date filed (Month, Day, Year)

OCT 2 3 2008 Ga lita M.D

Registrar DHMH 17 Rev 1/2001

State

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No. 2 U U 8 Certificate of Death 1. Decedent's Name (First, Middle, Last, 3. Time of Death 2. Date of Death Day **Physician** Month. 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Marley Neck Health Hone and Kehabilitation Hen Burnie 9. Birthplace (State or Foreign County) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** 1□M 2 🗗 🖡 Months Days 216-34-5717 Yrs. Director Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, if a Wedforl Eventual must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 ☐ Yes 2 No Maryland 10e. Street and Number 10g. Citizen of What Country? 12007 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 □Yes 2 □ No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: Back Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Vurses 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be unknown unknown ၉ 19b. Mailing Address (Street and Nymber or Rural Route Number, City of Town, State, Zip Code) 21225 10 Wallace AW. Brookly Tark. Maryland 19a. Informant's Name/Relationship (Type. Print) Kodney Black-gran grandson Department of Healt Important: If item 2 any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Parker Funeral 21. Signature of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Be Completed by Physician/Medical Examiner Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of). Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month 5 Other (specify) <u>Р</u> О 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗆 No 212 No 1 TYes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 5 ☐ Pending investigation 1 □Yes 2 □ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and tit of certifier 29c. License number 29d. Date signed (Month, Day, Year) 057028 0-22-08

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

23

2008

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygien

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	/Medic		Russell O. Beard	111				10-21-	2008	10:01A M
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	Funeral Director		213 10 0020 11	M 2□F 7. Age (In	yrs. last birthd	Months Days	Hours Min.	8. Date of Birth (Month, Day, 10-18-	Year)	Birthplace (State or Foreign Country) Md.
	and		Usual Residence of Decedent  10a. State 10b. County	100	. City, Town o	r Location				10d. Inside City Limits
	Manyll f sho	ō		Balto.			arr#110			1 ☐ Yes 2 No
	28a-	Director	10e. Street and Number	barto.		10f. Zip Code	sville	1	0g. Citizen of What	Country?
	with Se or	Ö	7914 Redstone F	Road			1087		USA	•
	death ms 2;	Funerai		12. Was Decedent Ever	in U.S. 1	13. Was Decedent of If Yes, specify Cub		pecify Yes or No-	14. Race - A	merican Indian,
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2	2 sh and is m		19a. Informant's Name/Relationship (Ty)	•	19b. M	ailing Address (Stree	and Number or Ru	ral Route Number	, City or Town, State	e, Zip Code)
a)	1 and Health em 27 sher t		Anita Beard 20a. Method of Disposition	Spouse	Oh Place of Di	7914 Redst sposition (Name of	one Road		L1c. Md. 20c. Location - City	
5	if it		1 X Burial 2 ☐ Cremation 3 ☐ R	emoval from State	cemetery, o	crematory`or other pla				
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Da	permit. Pages 1 am Department of Heali Important: If item 2 any injury or other once.		21. Signature of June 1 Service Lices	Ce .		22. Name and Address 9705			k Funeral ngham, Md	
П	*		23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on	cations that caused the	death. Do not	enter the mode of dy	ng, such as cardiac	or respiratory arri	est,	Approximate Interval Between
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	To the Hospital or Attend within 24 hours after death To the Funeral Diractor; completely filled in by the	edical (	29a. Certifier 1⊠ Certifying Phys (Check only one)	ician: To the best of my ner: On the basis of exar and manner stated.	knowledge, demination and/o	eath occurred at the t r investigation, in my	me, date and place opinion, death occu	, and due to the carred at the time, da	ause(s) and manner ate and place, and o	r as stated. due to the cause(s)
	To th Withir To th	Me	29b. Signature and title of certifier			29c. Licen	se number	2	9d. Date signed (M	onth, Day, Year)
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			1 - State Registrar	te of Marylan		artment of H		d Mental Hygi	ene2008	33/36
			Decedent's Name (First, Middle, Last)	<u>-</u>				2. Date of Death	1	3. Time of Death
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jain	/Medic Examin		4a. Facility Name (If not institution, give street a		WIIDOI	4b. City, Town, or	Location of D		4c. County of Deat	
	LXUIIII		327 South Lane			Eastor			Talbot	
	Funeral		Social Security Number 6. Sex	7. Age (In yrs. I	ast birthday)	If Under 1 Year	If Under 24		9. Birti	nplace (State or Foreign
	Director		240-94-9407 <sup>1⊠M 2</sup>	□F 63	Yrs.	Months Days	Hours N	July 3,	Year) Co	th Carolina
	ט		Usual Residence of Decedent							
	how How		10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
	e Ma	Ş	MD Talbot		Easto	n				1 ☐ Yes 2 No
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	d within 72 hours after death with the Maryland spiene. yiene. "neture!", or Iteme 23a or 28a-f ehow the Medical Examinar must be notified at	al	327 South Lane			21	601		USA	
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څ	should nd Men marke umatic	<u>٩</u>	19a. Informant's Name/Relationship (Type, Pri	ne)	10h Mailio	a Address (Street a	ad Alumbas a	s Russ I Route Number	City on Town State 3	in Code) unk
2	C/ G = 9		Talbot County Police	-	150. Mailin	g Address (Street a	ina ivamber a	r Rural Route Number,	City or Town, State, 2	ip Code) GIIK
o o	1 end Heelth am 27		20a. Method of Disposition	-	lace of Dispo	sition (Name of		Date 2	Oc. Location - City or	Town State
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UNISION	dea ctor	flca	3 Suicide 6 Could not be 28e	Place of Injury - At ho	me, farm, stre			28f. Location (Str.	eet and Number or Ru	ral Route Number.
$\leq$	Dir	Certificatio	4  Homicide determined	building, etc. (Specify	)	,,		City or Town,	State)	
	nours nor nere		29a. Certifier 1 Certifying Physician:	To the best of my know	wladge, dagth	occurred at the tim	a, date and pl	lace, and due to the ea-	uso(s) and it anner as	statod.
	to the hospital of Attending Privaling 24 hours effect death.  To the Funerel Director: After the completely filled in by the funeral	Medical	(Check only 2   Medical Examiner: Or	the basis of examinat d manner stated.	ion and/or inv	estigation, in my op	inion, death o	occurred at the time, da	te and place, and due	to the cause(s)
	within To th comp	ž	29b. Signature and title of certifie		101	29c. License	number	1 29	d. Date signed (Month	n, Day, Year)
			I I UD ( ee V la	DULL	W	\ \mathcal{L}	Yold	,84	10/20/0	8
			30. Name and address of person who complete	d cause of death (Item	23a) (Type. I	Print)	~~~~		1010	211063
			AUCE ANOR CAL	tours. un	D - 10	13 S.TALE	BOTST	STE 13 4	ST MICHA	8 E15,140
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DHMH 17 Rev 1/2001

Registrar

OCT 2 3 2008

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

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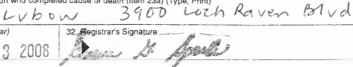
v requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit leted by Physician/Medical Examin	Gloria Bowers (da	aughter)	3609 Malde	n Avenue, I	Baltimore,	MD 2121	1				
Pages 1 a nent of Her ent: If item ury or othe	20a. Method of Disposition  1X Burial 2 □ Cremation 3 □ 1  14 □ Donation 5 □ Other (Specify,	Removal from State	lace of Disposition (Name emetery, crematory or othe sterstown UM	r place)		c. Location - City or isterstow					
permit. Departr Importe any inji	21. Signature of Funeral Service Licens	count	Buryee- 3631 Fa	Address of Facility Henss-Seitz 11s Road, F	Baltimore.	MD 2121	i				
	23a. Part1. Fur the disease, or comp shock, or heart failure. List only of	olications that caused the death one cause on each line.	n. Do not enter the mode of	f dying, such as cardiad	or respiratory arrest,		Approximate Interval Betw				
/Medical	Immediate Cause (Final disease or condition resulting in death)	a ASPIra+ Due to (or as a consequ		monia			Onset and D				
je je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b									
ate be exe hysician a he burial-i	resulting in death) Last  Due to (or as a consequence of):  d.										
he death certific the attending p ched for use as a	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)										
luires that I n signed by Id be deta d by Ph	artii. Othor significant conditions co	23e. Did tobacco use contribute to the cause of d									
The law requii ate has been s page 2 should											
Physicien: The lavithis certificate has all director, page 2	25. Was case referred to medical examiner?	Hospital:	ER/Outpatient 3 □ DOA	26. Place of Dec	ath (Check only one)		cify)				
inding Phath. r: After the funeral		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	Injury at Work? 1 Yes 2 No	28d. Describe how						
tel or Attending P s after death. el Director: After t ed in by the funera Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	me, farm, street, factory, o	ffice	28f. Location (Stree City or Town, S		ural Route Numb				
To the Hospitel or Attending Phymitin 24 hours after death.  To the Funerel Director: After the completely filled in by the funeral Medical Certification: T		ysicien: To the best of my kno liner: On the basis of examina and manner stated.	wledge, death occurred at tion and/or investigation, in	the time, date and place my opinion, death occu	a, and due to the caus irred at the time, date	e(s) and manner as and place, and due	s stated. to the cause(s)				
To the compliant Me	29b. Signature and title of certifier		29c. L	icense number	29d.	Date signed (Mont	h, Day, Year)				

For State Registrer 3. Time of Death 2. Date of Death October Year Bottevill 8:25AM E. 2008 Bertran 21 Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 3653 Keystone Avenue Baltimore If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 8. Date of Birth (Month, Day, Year) 01/20/1919 ocial Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 20-07-244 89 Maryland al Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits MD 1**XX** es 2 □ No N/A Baltimore 10g. Citizen of What Country? Street and Number 10f. Zip Code 3653 Keystone Avenue 21211 U.S.A. 12. Was Decedent Ever in U.S.
Armed Forces?
1 X Yes 2 \( \text{DNo} \) No
If Yes, Give
Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Army945 Specify: White 1 ☐ Yes 2 No Specify: 3 ♥ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) lementary/Secondary (0-12) Tire Builder Schenuit Tire 8th 18. Mother's Name (First, Middle, Maiden Sumame) Father's Name (First, Middle, Last) Arthur Botterill Bertha Gordon et and Number or Rural Route Number, City or Town, State, Zip Code) Informant's Name/Relationship (Type Print) e, MD 21211 20c. Location - City or Town, State Reisterstown, MD Home, Inc. MD 21211 Approximate Interval Between Onset and Death 2 weeks 23d. Date of delivery Month Year bacco use contribute to the cause of death? 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes ence 6 Other (Specify) ow injury occurred treet and Number or Rural Route Number, n, State)

State

Division of Vital Records, P.O. Box 68760,

Deborah



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Registrar

R110361

Baltmore

2008	3373	(
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Jame	es Napoleor	1	er State ( - For State degistrar	of Maryland / Depa <i>Cer</i>	artment of H rtificate of D		Mental Hy	/giene Reg.	2 U	08 3373
Med	Physicia Exami	in/	1. Decedent's Name (First, Middle,Last)	POLEON	BAKE	۵	4,75	2. Date of Death	ay Year	3. Time of Death 1732 hrs
f		-	4a. Facility Name (if not institution, give		4b.	City, Town, or L	ocation of Death	October 19,	4c. County of Death	
	Funeral		1833 Cedar Drive  5. Social Security Number 6. Sex	7. Age (In yrs. li		Severn f Under 1 Year	If Under 24Hrs	8. Date of Birth(	Anne Arundel  MM/DD/YYYY) 9. Bir	thplace (State or
	Director		258-242546	M 2 F 84	+ Yrs.	Months Days	Hours Min.	JAN. S	7, 1924 Foreign	ountry) IENNESSE
	any	-	Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Location					10d. Inside City Limits
	*	ē		RUNDEL S			_	5		1 Yes 2 No
	death with the Maryland or items 23a or 28a-f sho must he notified at once	Director	10e. Street and Number	AR DRIVE		of Zip Code	14	109	Citizen of What Cou	ntry?
	r death with the or items 23a	Funeral	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U Armed Forces?  1 Yes 2 No			anic Origin? ( Sp Mexican, Puerto	ecify Yes or No- Rican, etc.)	White, etc.	ican Indian, Black,
	ırs after Iural", o	à	Widowed 4 Divorced  15. Decedent's Education (Specify on	If Yes, Give Year or Dates: y highest grade completed)	1 Ye	es 2 No Usual Occupation	· · ·	vork done 1	Specify: W	
	36 thin 72 hou te. than "natedical Ext	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	,	•	A SOM	red)	CONST	RUCTION
	21215-0036  Juld be filed within 72 hours after Mental Hygiene. marked other than "natural", co event, the Medical Examiner.	Be Con	17. Father's Name (First, Middle, Last)  RLAINE B	AKER	1	1	8.Mother's Name	(First, Middle, Ma	iden Surname)	TH
	MD 21 d 2 should I th and Mer n 27 is mar	2	19a. Informant's Name/Relationship (Ty JAMES BAKER	pe, Print)	19b. Mailing A	ddress (Street	and Number or I	Rural Route Numb	er, City or Town, State	e, Zip Code) CICEYS VILLE
	alt alt		20a. Method of Disposition 1 Burial 2 Cremation 3	20b.	Place of Disposition crematory or other DENT	n (Name of cem	etery,		20c. Location - City of	
	Baltimore, permit. Pages I a Department of He Important: If ite injury or other tinjury or other tr	-	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licens		_		11.0,0	/ / 9		<u> </u>
			23a. Part I. Enter the disease, or compl	notices that governd the death	75	22 0	ONLE	JEY DE	STE N. HA	2/076 Nover, MD
1	Physician fedical		failure. List only one cause on each						t, Shock, of Heart	Between Onset and Death
	.aminer		or condition resulting in death)	Due to (or as a consequence of	of):	· · · · · ·	er -			
		iner	cause. Enter Underlying Cause	Oue to (or as a consequence o	of):	•				
	ed nsit	Examiner	events resulting in death, East	Oue to (or as a consequence of	of):					
	o, e be executed ysician and burial - transit	dical	UNPENDED d.	AMENDED						
	10 = =	n/Me	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of preg		death 3	Ectopic pregna	ancv	23d. Date of delive Month	ry Day Year
	that the death certificaned by the attending phedeached for use as the	Physician/Medical	past 12 months?  1 Yes 2 No 9 Unknown	Pregnant at time of do		· (Specify)				
	e es	ρ	Part II. Other significant conditions	contributing to death but not	resulting in the und	erlying cause gi	iven in Part I.			o the cause of death?
	of Vital Records, P.C is Physician: The law requires that ther this certificate has been signed I neral director, page 2 should be deta	Completed						24a. Was ar autops perform	y prior to	outopsy findings available completion of cause of
			25. Was case referred to medical			26.Place	of Death (Check	1 Yes 2	No 1 🗸 Y	es 2 No
	F Vital   Physician: r this certifi	To Be	1 ✓ Yes 2 No	ospital: 1 Inpatient 2	ER/Outpatient				Residence 6 🗸 Oth	er: Scene
	ion of tending Ph leath.	ation:	27. Manner of Death  1 Natural 5 Pending 2 ✓ Accident Investigation	28a. Date of Injury (Month, Day, Year) FOUND: Oct 19, 2008	FOUND: 1720 hrs		yatWork? ′es 2 ✔ No		owinjury occurred sed to low enviro	onmental
n	Division of Vital lothe Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certif completely filled in by the funeral director,	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h		factory, office bi	uilding, etc.	28f. Location (St or Town, Sta 1833 Cedar Dr	reet and Number or F ate) ive , Severn, MD	Rural Route Number, City
1	To the Hos within 24 h To the Fun	Medical (	( Sittle of the site of the si	an: To the best of my knowled On the basis of examination	-					
71	To with To	Mec	29b. Signature and title of certifier	and manner stated.		29c. License	e number	Т	29d. Date signed (M	onth, Day, Year)
			30. Name and address of person who	completed cause of death (flor	m 23a)	O.C.N	И.Е. ————		October 20, 200	08
			Melissa Brassell, MD As	sistant Medical Exami	,	nn Street, B	altimore, MD	21201		
	S Regis	tate	31. Date filed (Month, Day, Year)	36. Registrar's Signar	ture	,				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Morris Cook Alethea Enphemia 11:45p 10 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore 3610 Eitemiller Road If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2√2 F **Director** 216-20-1296 93 MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show am portant: if Item 27 is marked other than "natural", or items 23a or 28a-f show am portant if Item Medical Evaration rust be notified at once. **Funeral Director** 1 ☑ Yes 2 ☐ No MD NA Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21244 U.S.A. 3610 Eitemiller Road 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ If Yes, Give Year or Dates: Specify: Black Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) N/A College (1-4or 5+) Private Domestic Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Morris Mamie West ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cynthia Carey-Daughter 25 Dey Place, Edison, NJ 08817 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) Metro Crematory Inc 10/23/08 Baltimore, Md 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Baltimore, Md 21. Signature of Funeral Service Licensee 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 No Division of Vital 1 □ Yes 2 🗓 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) 1125 Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 → No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation reral Director: / 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier BD32717 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 701 7i6/712

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

Erbonso

32 Registrar's Signature.

Registrar

2008

	*			1- For Amend Items Registrer	State of Ma 23a PtI pe	arylar er d	nd / Depa	artmer 4.10 rtificat	ot of H	ealth a South Death	and M	ental Hy	giene Reg. No	2008	}	337	741
			1. Decedent's Name (First, Middle, Last)								2. Date of De Month	ath			3. Time of	Death	
Physician /Medical				Dona1d	I.	Cleckner						October 11, 2008			10:30	) A M	
Examiner			4a. Facility Name (If not institution, gi	ve street and number)	treet and number)			4b. City, Town, or Location of Death					. County of De	ath			
				Harford Memori	al Hospital	-		Havre de Grace				e Harford		larford			
	П	Funeral			Sex 7. Age 1 X M 2 ☐ F		last birthday) Yrs.	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.		Min.	8. Date of Bir (Month, Da	y, Year	) (	country	e (State o	or Foreign	
Director			213-30-1404 Usual Residence of Decedent		75	115.					Oct. 1	5, 1	1932 M	aryl	Land		
		land w		10a. State 10b. County	1	10c. Ci	ty, Town or Lo	cation							10d.	Inside Ci	ty Limits
		the Maryla r 28e-f ahov rotified at	to	Maryland Anne Arundel Glen Burnie								1 ☐ Yes 2				2 🔀 No	
		ith the Marylar or 28e-f ahow e nutified at	Directo	10e. Street and Number				10f. Zig	Code			10g. Citizen of What Co			Country	?	
		deeth with the Maryland ma 23a or 28e-f ahow r IT wat be notified at	a D	8009 Stone Haven	Drive			2	1060				J	J.S.A.			
		dee H	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U	I.S. 13.	Was Dece	dent of Hi	ispanic Ori	gin? (Spe	cify Yes or No Rican, etc.)	)-	14. Race - An Black, Wh			
	36	s afte	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ♣ Divorced	1 X Yes 2 □ N If Yes, Give	lo	1	1 ☐ Yes		Specify:		, , , , , ,		2			
4	Ö	within 72 hours after ene. than "natural", or Ita	d b	15. Decedent's 8	Year or Dates:		100 Bass	da ada 11	-1.0	-4'			1 400 14	W	hite		
0	5	in 72	lete	(Specify only highest g	rade completed)		16a. Deced (Give	kind of wo DO NOT u	ork done d ise retired	ation during mosi l)	t of workin	ng .	160. K	(ind of Busines	s/indus	try	
30	212	with iene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5- N/A	+)		laint						B.G.E.			
10	ğ	filed I Hyg other	Bec	17. Father's Name (First, Middle, Las	t)					18. Mothe	r's Name	(First, Middle	, Maider	Sumame)		_	
	la	ould be Menta Markad Markad	To B	John		Cle	ckner			Marga	aret	M	ary	D	unn		
	Baltimore, Maryland 21215-0036	is 1 and 2 should be filed within 72 ho of Health and Mental Hygiene. Itam 27 ia markad other than "natur other traumatic avant, if a Medical	-	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Address	s (Street a	and Numbe	or Rural	Route Numb	er, City	or Town, State	Zip Co	ode)	
	Σ	and 2 palith n 27 i		Nancy Anello (Da	ughter)		8009	Ston	e Hav	en D	rive	Glen B	urni	le, Mar	y1ar	nd 21	.060
80	ore	of He		20a. Method of Disposition 1 ⊕ Burial 2 ☐ Cremation 3 (	Removal from State	(	Place of Dispo cemetery, crer	matory or o	other place			ate		ocation - City o			
5	Ĕ	Pag ment ant: ury c		4 □Donation 5 □Other (Spec		Cro	ownsvil	le V	.A. (	Cem.	10/17	7/08	Crow	nsvill	e, N	Maryl	and
0-11-01	3all	permit. Pages Depertment of Important; If I any Injury or one		21. Signature of Funeral Service Lice	ensee		36	Name a	ly Addres	Sof Faculity	ăk Fu	neral	Home	P.A.			
)		705 e d		JUT 1	lle			204 1	Yount	ain J	Road	Pasade	na,	Mary1a			
				23a. Part. Enter the disease, or cor shock, or heart failure. List only	y one cause on each lin	е.			_		cardiac or	respiratory a	rrest,		In	oproximate terval Bet nset and I	ween
		Physician /Medical		Immediate Cause (Final disease or condition resulting in death)			ine.										
al	1	Examiner		f	Due to (or as a	consec	L.		********	schem	ic C	ardiomy	yopa	thy			
1			<u>-</u>	Sequentially list conditions,	b. Due to (or as a	Due to (or as a consequence of):							-				
3		nted I Insit	n in	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Severe Congestive Heart Failure						1ure	'e					
CA	Ċ,	execting and in and initial-tree	Examiner	that initiated events resulting in death) Last		consequence of):							-				
LECKNER	8760,	icate be executed physicien and s the burial-transit		(	Dila	ated	Ø V	Ventrical									
9	9	law requires thet the death certificate be executed as been signed by the ettending physicien and 2 should be detached for use as the burial-transit	Completed by Physician/Medical														
	al Records, P.O. Box	eath certific ettending p for use as f	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of 1 Live birth			Ectopic p	rennancy					23d. Date of d	,		
9	. B	ne dea the ett hed fo	sicia	in the past 12 months?	4☐Pregnant at			Other (se						Month	Da	y 1	r'ear
136	P.0	thet the ded by the detached	Phy	9 Unknown													
DOWALIS	Ś	res the igned be det	by	Part II. Other significant conditions	contributing to death bu	it not res	sulting in the u	nderlying (	ause give	n in Part I.				use contribute			
8	oro	v requir been si should	ted			·				<u> </u>		10	Yes 2	DXNo 3□1	robabi	y 4 ∐L	Jnknown
	lec	e law has b	nple									24a. Was autor	osy	24b. Were prior to	compl	findings etion of c	available ause of
1	E	: The la cete has	Cor									perfo 1 ☐ Yes	2 No	death1		No	
jale	نظ	ician: Th certificete rector, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othe			(Check only o					
100	7	Phys this aldi	: To	1 ☐ Yes 2 🔀 No 27. Manner of Death	1 Minpatier		ER/Outpatien			4   190				6 □Other (Sp	ecify)		
372	ر مر	tanding leath.  tor: After the funer	tlon	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day	Year)	Injury	M	28c. Injury Work	rai ≀? Yes 2∐1		8d. Describe l	now infu	ry occurred			
30	<u> S</u>	Attand death ctor: /	Certification;	3 Suicide 6 Could not l	28e. Place of Inju	ry - At h	ome, farm, str					8f. Location (	Street ar	nd Number or I	Rural R	oute Num	ber.
24	à	efter Dire d in b	ertl	4 Homicide determined	building, etc	. (Specil	(y)		,,			City or Tox	wn, State	9)			
2 Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office 29f. Location (Street and Number or Rural Route Number of Ru																	
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Certifier (Check only one)  29c. Certifier (Check one)  29c. Certifier (Check one)  29c. Certi								:)									
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)																	
		(11)		•	Juna .			L	>00	68	016	1	10	11110	8		
	1	31 Y	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  NASR/N  THUR 501 South Union Avenue Havre de Grace Maryland 21078									179					
		1/		NASRIN J	HUQ 22 Pariors				ion A	avenu	е нач	re de	Grac	e mary	Tan(	1 71(	7/0
		Sta Registr		31. Date filed (Month, Day, Year)	008 32 Registra	s signa	IIII O	Carles P									

08-07837 Leshell Campbell Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Manyland / Department of Health and Mental Hydiene

	State of Maryland / Department of Health and Wental 1-For State Certificate of Death	Reg. No.	2008 3374
Physician/	Registrar  1. Decedent's Name (First, Middle,Last)	2. Date of Death	3. Time of Death 2133 hrs
Medical Examiner		Month Day October 17, 200	. County of Death
	4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of De Baltimore	eau . 40	N/A
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Months Days Hours	Hrs. 8. Date of Birth (MM/ Min. 7 – 27 – 69	DD/YYYY) 9. Birthplace (State or Foreign Country) NY
Director	213-90-3388	7-27-09	
e e.	10a. State 10b. County 10c. City, Town or Location 10h N/A Baltimore		10d. Inside City Limits 1 XYes 2 No
the Maryland or 28a-f show illied at once.	10e. Street and Number 10f. Zip Code	10g. Citi	zen of What Country?
the Man or 2 wiffied	3002 Windsor Ave 21216		JSA
r death with or items 23	11. Marital Status 1 Never Married 2 Married 2 Never Married 2	(Specify Yes or No- uerto Rican, etc.)	14. Race - American Indian, Black, White, etc. African
ral", o	3 Wildowed 4 Divorced or Dates:	d of work done	Specify: American Kind of Business/Industry
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5-0036 ed within 72 hour lygiene. other than "natu the Medical Exan Completed	Laborer		
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than ic event, the Medical To Be Comple		Name (First, Middle, Maider va Stewart	Surname)
d be fill fental I fental I event.	Reserve Hee Hills		City or Town, State, Zip Code)
1D 21 2 should 1 and Me 27 is ma matic ev	Shelya Steward/Mother 3002 Windsor Ave		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she Injury or other transmatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	1 Burial 2 X Cremation 3 Removal from State Bayview Crematory	Date 20c.	
Baltin permit. Pa Departmer Importau Injury or	21. Signature of Funeral Service icense 22. Name and Address of Facility H	Mari P. Clo	se F.Svs.PA 21206-5105
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card	diac or respiratory arrest, sh	Approximate Interval Between Onset and
/Medical aminer	failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Acute Respiratory Distress Syndrome  Due to (or as a consequence of):		Death
	Sequentially list conditions, b. Due to (or as a consequence of):		
nine nine	if any, leading to immediate  causa. Enter Uncerlying Caus  (Disease or injury that initiated  C.		
50, te be executed spysician and burial - transit	events resulting in death) Last  Due to (or as a consequence of):  d.		
to be executed by spician and burial - trans	UNPENDED AMENDED		3d. Date of delivery
6876C certificate nding phys	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic p	pregnancy	Month Day Year
	past 12 months?  4 Pregnant at time of death 5 Other (Specify)  g Unknown		Oct 11, 2008
. 4 >4 0			o use contribute to the cause of death?  No 3 Probably 4 V Unknown
B, P.C. Lires that a signed d be dett	Hypertension; Diabetes Mellitus; Hepatitis C Infection; Recent Cesarean Section	24a. Was an	24b. Were autopsy findings available
Records, I The law requires ficate has been sig r, page 2 should be		autopsy performed	prior to completion of cause of death?
Rec The licate page	26 Place of Death (C		No 1 Yes 2 No
ital Recition: The certificate rector, page	25. Was case referred to medical examiner? Hospital: 1 Innation: 2 FR/Outnation: 3 DOA Other, 4		dence 6 Other:
of Viring Physical After this Funeral dir	27 Mapper of Death 28a, Date of Injury 28b, Time of Injury 28c, Injury at Work?	. 28d. Describe how i	njury occurred
OD (  tending sath.  or: All the fur	1 V Natural 5 Pending 1 Yes 2 Natural 5 Pending 1 Yes 2 Natural 1 Yes 2 Natural 1 Yes 2 Natural 2 Natural 1 Yes 2 Natural 2 Natural 1 Yes 2 Natural 2 Natural 2 Natural 3 Natura		
Division of Vital Records, P.O. Hospital or Attending Physician: The law requires that it 24 hours after death. After this certificate has been signed by tely filled in by the funeral director, page 2 should be detac	2 Accident Investigation 3 Suicide 6 Could not be determined 4 Homicide Could not be determined (Specify)	28f. Location (Stree or Town, State)	t and Number or Rural Route Number, City
Di To the Hospital within 24 hours a To the Funeral I completely filled		ce, and due to the cause(s) urred at the time, date and	and manner as stated. place, and due to the cause(s)
To wit To con	1.	1	d. Date signed (Month, Day, Year)
	Me and o.c.m.E.	0	ctober 18, 2008
3	30. Name and address of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 111 Penn Street, Baltimore	re, MD 21201	
Stat Registra	Ultil (. a) (1010) Streets down 499 According		

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Coste

29c. License number

D66063

October 21, 2008

State of Maryland / Department of Health and Mental Hygiene amend #23e,23b &24b Per Phy 6884 10/23/08 JH Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 2:00A M October 6eneva Dubase 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Randallstown Deasons Hospice-Northwest Hospital If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 1 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day 04 26 6. Sex **Funeral** 1 □ M 2 🔀 F Days 214.72.8147 **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant: If item 27 Is marked other than "natural", or Items 23a or 28a-f show Lry or other traumatic event, It w Modical Exprinter reast the modified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Ba Itimore 1 XYes 2 ☐ No MD **Funeral Director** 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Barnson Avenue USA 21215 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Mallo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Black Specify: Be Completed by 3 ☐ Widowed 4 ☒ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Receptionist Church 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ward Eddins Odesser Whitaker ၀ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) partment of Health a portant: If item 27 Is injury or other trau 4763 Melbourne Road Baltimore MD 21229 Alvin J. Eddins, Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department o Important: If any injury or Woodlawn, MD Woodlawn Centern 10/20/08 22. Name and Address of Facility Vaughn C. Greene Funeral SVCS 21. Signature of Funeral Service Licenses Vaush Randalistown MD 21133 iberty Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head fallure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Motastate /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed the burial-trans Due to (or as a consequence of): P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🛂 🗫 Year Month 5 Other (specify) cate has been signed by the page 2 should be detached in 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably XX Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐ Yes 2 X No 1 □Yes 2 A No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ■ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) SUNSOW) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Medical Certification: To nours after death.

neral Director: After this

filled in by the funeral d 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 M Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Octobor 14, 2003 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 25 MAIN STICEST REISTENSTOWN MO Ucharah 1000 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 23 2008

DHMH 17 Rev 1/2001

Registrar

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Villiam Levon Da		Jr. State - For State	of Maryland / Depai	tificate of	Death		20	08 3374
	R	enistrar		uncate or	Death	2. Date of Death	. No.	3. Time of Death
Physicia: Medical Examin	_	. Decedent's Name (First, Middle,Las	Davis	To		Month October 14	Day Year , 2008	0916 hrs
viermai Examin		4a. Facility Name (if not institution, give	ve street and number)		4b. City, Town, or Location of		4c. County of Dea	ath
		3510 Lynchester Road	,		Baltimore	velice	-	
Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs. Ia	ast birthday)		er 24Hrs. 8. Date of Birt	(MM/DD/YYYY) 9. E	Birthplace (State or eign
Director	1	186-24-8742 15	(M 2 F (@3	Yrs	Months Days Hours	Min. 3-25		Country)
	-	Usual Residence of Decedent				115-42.1	27.50	10d. Inside City Limits
any	F	10a. State 10b. County	10c. City,	Town or Local	tion			1 Yes 2 No
nd <b>show</b>	_	MD	130	Utim			(111)	
Aaryland 28a-f show 1 at once.	Director	10e. Street and Number			10f. Zip Code	110	g. Citizen of What Co	ountry?
r death with the Maryland or items 23a or 28a-f sho must be notified at once.	吉	1771 Homes	stead Stre	et_	21218		<u>U5</u>	4
with	Funeral	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13. Wa	as Decedent of Hispanic Ori Yes, specify Cuban, Mexicar	gin? ( Specify Yes or No- ı, Puerto Rican, etc.)	14. Race - Am White, etc	erican Indian, Black,
death or iten	Š	1 Never Married 2 Marrie	1 Yes 2 No				Specific P	Black
after all, o	à.		d If Yes, Give Yaar or Dates:	1 L	Yes 2 No specify nt's Usual Occupation (Give	kind of work done	16b. Kind of Busines	ss/Industry
hours		15. Decedent's Education (Specify of	College (1-4 or 5+)	during n	nost of working life. DO NOT	use retired)	gana	htop -
136 hin 72 hours afte e. Han "natural", edical Examiner	흶	Elementary/Secondary (0-12)	College (1-4 of 54)	Mod	+ Cutto	0	HOLE	Ne -
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sh injury or other traumatic event, the Medical Examiner must be notified at once	Completed	17. Father's Name (First, Middle, Las	st)	110	18.Mothe	r's Name (First, Middle, I	Maiden Surname)	
15-	BeC	William 1. To	V15 50		Ma	ry Sew	ard	
21215-00 uld be filed wit marked other c event, the M	0	19a. Informant's Name/Relationship	(Type, Print )	NI	ng Address (Street and Nu	mbe Rural Route Nur	ber, City or Town, Si	tate, Zip Code)
MD and 2 shoulth and m 27 is aumati	٦	William 1. Da	VIS III (SON		14 Eldor	1e. G-13	ato.M	D 3/308
ore, MD ss 1 and 2 sho of Health and If item 27 is her traumati	ı	20a. Method of Disposition	_	Place of Dispo	sition (Name of cemetery, other place)	Date	20c. Location - City	or Town, State
10F ages ont of other	- 1	1 Burial 2 Cremation 3	Removal from State	arisa	Frost Canely	10/24/20	B OWING	25 Mills MD
Baltimore, permit. Pages I as Department of He Important: If ite	ł	4 Donation 5 Other Special 21. Signature of Funeral Service Lio		*	one and Address of Facil	Troone F	METAL	Services
Ba mp Depu	- 1	0113	M0140	1/ 12	1905 LORI	C/2. B	ildo.M.	021212
Physician	$\neg$	7a. Part I. Enter the disease, or con	inplications that caused the death	n. Do not enter	the mode of dying, such as	cardiac or respiratory arr	est, shock, or heart	Approximate Interval Between Onset and
Medical	4	failure. List only one cause on Immediate Cause (Final disease	a. Hypertensive Atherosc	lerotic Care	diovascular Disease	51		Death
(aminer	- 1	or condition resulting in death)	Due to (or as a consequence of					
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uted id ransit			d					
760, ficate be executed 3 physician and the burial - transit	n/Medical	UNPENDED	AMENDED					
8760, ifficate being physicials the burit.	Mec	IF FEMALE:	23c. If yes, outcome of pre-		. [7]		23d. Date of del Month	ivery Day Year
37	2	23b. Was decedent pregnant in the	1 Live birth	2	Fetal death 3 Ecto	pic pregnancy	Monut	Day 1661

Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certi within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as Be Completed by Physicial

3b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	1 Live birth 2 Fetal death 3 Ectopic pregnar 4 Pregnant at time of death 5 Other (Specify) 9 Unknown	ncy . M	Month Day	Year
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.		se contribute to the c	
		24a. Was an autopsy performed?	death?	y findings available letion of cause of 2 No
25. Was case referred to medical examiner?	26.Place of Death (Check of Hospital: 4   Innation: 2   ER/Outnation: 3   DOA   Other Nursin		nce 6 🗸 Other: Sce	ene

Be	examiner? Hos	spital: 1 Inpatient 2 E	R/Outpatient 3	DOA Other Nursi	g Home 5 Residence 6	✔ Other: Scene
ion: To	27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occur	red
ertificati	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At hor	me, farm, street, factor	ry, office building, etc.	28f. Location (Street and Numb or Town, State)	per or Rural Route Number, City
dical C	29a. Certifier 1 Certifying Physician one) 2 Medical Examiner: C	n: To the best of my knowledge On the basis of examination and and manner stated.	e, death occurred at the distribution of the d	ne time, date and place, and ny opinion, death occurred	due to the cause(s) and manne t the time, date and place, and	er as stated. due to the cause(s)
Ne	29b. Signature and title of certifier	and manner stated.	2	9c. License number	29d. Date sig	ned (Month, Day, Year)
_	D 0.	. D. O.O.	q	O.C.M.E.	October 1	5, 2008

30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner

111 Penn Street, Baltimore, MD 21201

31. Date filed (Month, Day, Year) State Registrar

32 Registrar's Signature THE STATE OF

2008

eter James Ell		Sta 1- For State Registrar	ite of Maryland / I	Departmer <i>Certificat</i>			d Mental		Reg. No.	201	08 3374	
Physici Medical Exami		Decedent's Name (First, Middle     Peter James E	_		2. Date of De Month	Day	Year	3. Time of Death 1930 hrs				
er :	1101	4a. Facility Name (if not institution			4	o. City, Town, or	Location of De	October ath		ounty of Deat		
		1310 Roxborough Rd.				Rosedale				imore Co		
Funeral Director		Months Days Hours Min.						⁄lin.	8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country)  Jan. 25.1980 MA			
any		Usual Residence of Decedent  10a. State 10b. County	110	Oc. City, Town or	Locatio	n		7,417	**		10d. Inside City Limits	
<u>*</u> .	Ļ	MD Baltimore Rosedale									1 Yes 2 X No	
Maryland 28a-f show d at once.	Director	10e. Street and Number		110000		10f. Zip Code	_		10g. Citizen	of What Cou	untry?	
ith the Maryland 23a or 28a-f sho notified at once.		1310 Roxboroug				21237			US			
72 hours after death with the Maryland "n"natural", or items 23a or 28a-f sho al Examiner must he notified at once	Funeral	11. Marital Status 1 X Never Married 2 Mar	12. Was Decedent Everried Armed Forces?			Decedent of Hi s, specify Cuba		( Specify Yes or Nerto Rican, etc.)	0-   14.	Race - Ame White, etc.	rican Indian, Black,	
after de al", or	by Fu	3 Widowed 4 Divo	1 Yes 2 X	No	1	Yes 2X No specify:			Spe	ec <i>ify:</i> W	hite	
hours : 'natur's Exami		15. Decedent's Education (Speci	<del>- , </del>	du		ent's Usual Occupation (Give kind of work done most of working life, DO NOT use retired)				of Business	/Industry	
136 hin 72 e. than "	Completed	Elementary/Secondary (0-12) 12	College (1-4 or 5+)	·	arma	cy Tech	1		Phar	macy		
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2121! uld be fil Mental F marked c event, 1	o Be	Frederick Elli  19a. Informant's Name/Relationsh		100	Mailing	Addross (Stee		Sa Harri		r Town Stat	a Zin Code)	
sho and and and artis	2	Frederick Ellis	, , , ,			Fleetwo				MD 2		
re, M I and 2 Health if fitem 2'		20a. Method of Disposition	3 Removal from State			ion (Name of ce	emetery,	Date			r Town, State	
Baltimore, permit. Pages I ar Department of Hee Important: If ite		4 Donation 5 Other Spe		Gardens	s of	Faith		10/18/08		timor		
Baltimore, M permit. Pages I and 2 Department of Health Important: If item 2 injury or other traun		21. Signature of Funeral Service L	icensee	>	22. Na	ame and Addres	s of Facility Mj				1 Home, Inc.	
Physician	h_ (1)	23a. Part I. Enter the disease, or		e death. Do not e				Baltin ac or respiratory a			Approximate Interval	
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6876 certificate nding phy se as the l	M/us	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth	of pregnancy	Fet	al death 3	Ectopic pre	gnancy		ate of delive onth	ry Day Year	
Box 6876( ne death certificate the attending phy hed for use as the b	Physician/M	1 Yes 2 No 9 Unkr	4 Pregnant at tin	me of death 5	Oth	er (Specify)						
ision of Vital Records, P.O. Box 68760 Attending Physician: The law requires that the death certificate releath.  ector: After this certificate has been signed by the attending physby the funeral director, page 2 should be detached for use as the b		Part II. Other significant condition		out not resulting i	n the ur	nderlying cause	given in Part I.	23e. Did	tobacco use	contribute to	o the cause of death?	
<b>P.O.</b> irres that the signed by the detached	d by							_ 1 _ Y	es 2 🗸 N	o 3 Pro	obably 4 Unknown	
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Division of Vital Records, tal or Attending Physician: The law requir is after death.  al Director: After this certificate has been seled in by the funeral director, page 2 should I	Be	25. Was case referred to medical examiner?	Hospital:   Innation	0 ED/0.4	-4:4		e of Death (Che		Tp. 14.	0 0 00		
n of V ling Phys After thi funeral di	-: To	1 ✓ Yes 2 No 27. Manner of Death	28a, Date of Injury	28b. Tir			ry at Work?	rsing Home 5 28d. Describe	e how injury	occurred	er: Scene	
ion tendin eath.	ation	1 Natural 5 Pendi 2 Accident Invest	ng FOUND: Day, Year	r) FOUN 1925 h		1	Yes 2 🗸 No	Subject sh	ot self			
Division spital or Attencours after death neral Director:	Certification:	3 Suicide 6 Could	not be 28e. Place of Injur	-	n, stree	t, factory, office	building, etc.	or Town.	State)		Rural Route Number, City	
in g bi		4 Homicide determined	(Green) Singi			ad at the time.	late and place	1310 Roxbo				
Division  To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only 1 Certifying Phy	ysician: To the best of my k niner:On the basis of examin and manner stated.									
- F 18 F 18	Me	29b. Signature and title of certifier				29c. Licen:	se number		29d. Dat	e signed (M	onth, Day, Year)	
O.C.M.E. October 12, 2008							08					
5		30. Name and address of person v	who completed cause of dea nt Medical Examiner		Stree	t, Baltimore	MD 21201					
	tate	31. Date filed (Month, Day, Year)	32. egistrar's		1						<u>-</u>	
Regis		<u> </u>	2008	1 15. 1.					2.44	,		
DHMH 17 Rev 1/2	001			ODIC	LAIMIC				OGIVIO	-		

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Da 10-21-2008 **Physician** Dorothy L. Emminger 8:35P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Gilchrist Center 6. Sex Towson Balto. 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 F Months Days Hours Min. 216-20-6414 80 Director 3-29-1928 Md. Usual Residence of Decedent 10b. County 10c, City, Town or Location 10a. State 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2X No Md. Balto. Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 3517 Hiss Avenue 21234 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 Never Married 2 Married 1 ☐ Yes X☐ No Specify. þ Specify: White Widowed 4 □ Divorced than "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiene Important: If item 27 is marked other the any injury or other traumatic event, ITS 1008. Telephone Operator Phone Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Oliver Amos Lillian Carroll ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gerald DiLeonardi Son 1120 Old Eastern Avenue Essex, Md. 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Moreland Memorial 10-25-2008 4 □ Donation 5 □ Other (Specify) Balto. Co. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimun ek Funeral HOme Hecci 9705 Relair Rd. Nottingham, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician wron.c 65th disease or condition resulting in death) /Medical Due to (or as,a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner sician and X law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): physician s the burial Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed 2 No 2 🗆 No 1 ☐ Yes : After this certifics funeral director, r Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 Pending investigation 1 Natural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10 N. Clintes S. Jabo. md Ziedy 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6700 AMC 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2008 3 Registrar

2

Maryland 21215-0036

Baltimore,

Box 68760,

P.0.

Division of Vital Records,

Emminger

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** Ford 10:30p. Katherine 10 20 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Manor Care Nursing Home If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 06 15 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Months Days Hours Min 1□ M & F 81 Director 218-34-2230 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County r 28a-f show notified at 1 Yes 2 No Director Baltimore NA 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ms 23a or r must be r U.S.A. 21216 5814 Plummer Ave Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or items 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify Completed by 3 Widowed 4 Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry of Health and Mental Hygiene.
Item 27 Is marked other than "natu other traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Beautician Beauty Shop 12th grade na 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any injury or other traumatic event Be Idabelle Goings James Green 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21216 5814 Plummer Ave, Baltimore, Md Frank Ford Sr.-Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Owings Mills, Md Garrison Forest Vet 10/27/08 21. Signature of Funeral Service Licensee March Fr H West rome 4300 Wabash Ave, Baltimore, Md 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ASCUD **Physician** /Medical Due to (or es a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical as attending p d for use as IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy 5 □ Other (specify) \_\_ 1 ☐Live birth 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4. White Nown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed page this certificate 1□ Yes 2 [] NO To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, F. 25. Was case referred to Medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ №6 1 Inpatient 2 ER/Outpatient 3 DOA 2 27. Mann of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural (Month, Day Year) Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Namedu Roman 8813 Wordham words - Swite Toy - MD 21234,

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

**ORIGINAL** 

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar amend 6 per F.H. g888 2/20 65 tificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** /19n trazier 18, 2008 October /Medical 3:45 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Greater Baltimore Medical Center Towson Baltimore 5. Social Security Number 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Min. N/A Director 10.18.2008 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show Baltimore Mes 2 No Completed by Funeral Director 10e. Street and Number 10g. Citizen of What Country? edonia 21206 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ Ho
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) infant infant Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be is marked Erica Mazier ၉ other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health an Important: If item 27 is any Injury or other trau 5805 Cedonia Baltimore 21206 Erica WD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Greenmoont Baltimore, Mi mount 10/24/2008 | Baltimore, MI)
22. Name and Address of Facility Coughn C. Greene Fareral Services 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 4905 York Ad Baltimore, MD 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner REME Sequentially list conditions, if any, leading to infimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Year 5 Other (specify) 9 Unknown 9 Unknown certificate has been signed by rector, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No autopsy performe 2 No 1 ☐ Yes 25. Was case referred to medical Certification: To Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Deeth the funeral 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident s after death 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide To the Hospital o within 24 hours aff To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0064730 10, 21, 2009 ruisa 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) , 6701 N. CHARLES STREET, BAUTIMORE, MD 21204 MEZU-NDUBUIS!

State

Registrar

31. Date filed (Month, Day, Year)

Bull

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death October 20, 2008 **Physician** Рм 7:59 Harry Albert Granruth Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4019 Baker Lane Nottingham Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

April 22,1932 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) Funeral 1 X M 2 □ F 76 218 28 1967 Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan D partment of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinant must be profifted at orde. 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 217 No Director Nottingham Maryland Baltimore 10e. Street and Number 10g. Citizen of What Country? 4019 Baker Lane 21236 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? 1 Q 5 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status 1950-Black, White, etc. 1X Nes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🛮 No Specify. Specify: White 1954 ģ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Supply Scheduler Department Of Army 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mabel Williams Harry Albert Granruth, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6 Hallview Ct. Nottingham, Maryland 21236 Stanley Gruzs (Stepson) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Mem. Gardens 10/24/2008 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Maryland 21221 Lichael 23a. Part 1. Enter the disease, or coordication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Cardovascular Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within £2 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriar-transit completely filled in by the funeral director, page 2 should be detached for use as the buriar-transit resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 □ Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \subseteq Nursing Home 5XX Residence 6 \subseteq Other (Specify) 1⊠Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Octder 21, 2008 Name and address of person who completed cause of death (Item 23a) (Type, Print) 4920 Cayler 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Year Graham VVIS 2008 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner ownown If Under 24 Hrs. Hours Min. If Under 1 Year Un vrs. last birthday Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Months Year 1√2 M 2 □ F Yrs. Director 213-68-2422 .17,1957 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Evair in a trust by routhed at any injury or other traumatic event, I'm Medical Evair in a trust by routhed at any injury or other traumatic event, I'm Medical Evair in a trust by routhed at any once. 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County Director 1 Yes 2 No Md N/A Baltimore 10e. Street and Number 10f, Zip Code 10g, Citizen of What Country? by Funeral S A Race - American Indian, 882 Benninghaus Rd 21212 Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1977-80 1 Never Married 2 Married 1 ☐ Yes 2大 No Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 2years Computer Technician IRS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be eMorris H. Graham Sr. Annie Evans 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Benninghaus Rd. Balto., MD 21212 Annie Graham/Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GreenmountCrematoryOct22,08 Balto.MD 21. Sur rure of Fun ral Service Licenses 22. Name and Address of Facility CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO. MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Se **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any lading to cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit Due to fras a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 1 ☐ Yes 2 X No 1 ☐ Yes 25. Was case referred to medical examiner? 1 ☐ Yes 2 No director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, ohysician this After

Baltimore, Maryland 21215-0036

attending physic for use as the b signed by the a certificate has been rector, page 2 should within 24 hours after death.

To the Funeral Director: A completely filled in by the fu To the Hospital

> State Registrar

DHMH 17 Rev 1/200

29a. Certifier

30. Name

(Check only one)

29b. Signature and title of certifier

and address of person who cor

3

cause of death (Item 23a) (Type, Print)

Registrar's Signature

och

1 🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

aven

29d. Date signed (Month, Day, Year)

Blvd., Baltmore, MD 21239

			For State Registrar	State of Ma		artment of Hea rtificate of De	ath	Reg. No	0000	33753
	Physici /Medic	an	Decedent's Name (First, Mide	<sub>dle, Last)</sub> Jeraldine Ros	seanne Ger	ntle		2. Date of Death Month Da Oct 1	Year <b>9, 2008</b>	3. Time of Death  9:40 AM
	Examin		4a. Facility Name (If not institution	on, give street and number) e's Supreme Care		4b. City, Town, or Loc	Columbia	40	c. County of Death	ward
	Funeral Director		5. Social Security Number 141-30-3938		e (In yrs. last birthday)  69 Yrs.	If Under 1 Year If		8. Date of Birth (Month, Day, Year, Jun 13, 1	9. Birthp Coun	lace (State or Foreign try) NJ
	yland now at		Usual Residence of Decedent  10a. State 10b. Count	у	10c. City, Town or Lo	ocation			1	Od. Inside City Limits
	he Mar 8a-f sl	ector	MD	Howard		107 7: 0:1:	Columbia	100 0	itizen of What Coun	1 □Yes 2 No
	a or 2	I Dir	10e. Street and Number 6158 Steven Fore	st Rd.		10f. Zip Code	21045	Tog. Ci	U.S	
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland tt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Ma 3 Widowed 4 X Divorce	12. Was Decedent Armed Forces? 1 ☐ Yes 2 X	Ever in U.S. 13.	Was Decedent of Hispa If Yes, specify Cuban, N 1 □ Yes 2 No S	anic Origin? (Spe Mexican, Puerto F Specify:	cify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: W	
Maryland 21215-0036	hin 72 hou e. an "natura Medical E	Completed by	15. Decede	ent's Education lest grade completed)	16a. Dece (Give	dent's Usual Occupatio kind of work done duri DO NOT use retired)	ng most of workin	16b. F	Kind of Business/Ind	,
12	filed within Hygiene. Ither than '	Con	17. Father's Name (First, Middle	o ( oot)			maker Mother's Name	(First, Middle, Maide	at h	ome
and	d be fi	To Be	17. Father's Name (First, Middi	John Fer	nton	10	. Moulet 3 Name		h Maslak	
ary	should be and Mental s marked o	Ě	19a. Informant's Name/Relation			ng Address (Street and	Number or Rura	l Route Number, City	or Town, State, Zip	Code)
	1 and 2 Health a em 27 is		Thomas Gentle		20b. Place of Dispo	26 Gray Sea Wa	•	·	ocation - City or To	Num State
Baltimore,	Pages 1 Iment of H tant: If ite Jury or otl		4 □ Donation 5 □ Other		cemetery, cre	matory or other place) c Crematory, LLC	Oct	22, 2008		urnie, MD
Bal	permit. Pag Department Important: I any injury o		21. Sign all relof Fureral Salvio	MUDULT	401293	3871 Old (	eral Home, I Columbia Pi	ke Ellicott City,	MD 21043	
	Physician	V I	shock, or heart failuide. Li Immediate Cause (Final disease or condition	or complications that cause st only one cause on each li	ne.	_				Approximate Interval Between Onset and Death
1	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):	he Cardiov Myocardial Myresten	infacti	v		
	Do its	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):	1.1.1	A tim to			
68760, <	ficate be executed physician and sthe burial-transit	al Examiner	that initiated events resulting in death) Last	cDue to (or as	a consequence of):	Mypersen	More.			
	tificate g phys as the	ledical		d						
P.O. Box	law requires that the death certifi as been signed by the attending I 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		2 ☐ Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of delive Month	ery Day Year
	w requires that the de been signed by the should be detached	by	Part II. Other significant cond	itlons contributing to death b	out not resulting in the u	underlying cause given i	in Part I.		use contribute to t	he cause of death?
Il Records,	The ate has page	Completed						24a. Was an autopsy performed? 1☐ Yes 2 Ø N	prior to co death?	opsy findings available impletion of cause of 2 ☐ No
Vita	Physician: The this certificate ral director, pag	Be	25. Was case referred to medi examiner?	Hospitali	ant OFFE Contration	Othor		(Check only one)	0. 7/1 (0	M ASTISTED ling
Division or Vital	Attending Physrdeath. ector: After this by the funeral di	tion: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pen 2 Accident inve	28a. Date of Inj		of 28c. Injury at Work?		me 5 ☐ Residence 28d. Describe how inj		ny) / 1 3 4 1 3 4 4 7 7 7
Divisi	al or Atter after dea' I Director d in by the	Certification:	3 ☐ Suicide 6 ☐ Cou		jury - At home, farm, st tc. <i>(Specify)</i>	treet, factory, office	1	28f. Location (Street a City or Town, Sta		al Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical C	29a. Certifier 1 Certification (Check only one) 1 Medic	ying Physician: To the best al Examîner: On the basis of and manner s	of examination and/or in	th occurred at the time, nvestigation, in my opin	date and place, ion, death occurr	and due to the cause red at the time, date a	(s) and manner as s nd place, and due t	stated. to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certi	fier		29c. License n			ate signed (Month,	
			> 561cm				0641	06	hober 21	2001
	3		30. Name and address of pers	on who completed cause of	Back River	Print) NECK Road	Balhn	nore Mary	1 and 2127	2 /
	St Regist	ate rar	31. Date filed (Month, Day, Ye. OCT 2 2	ar) 32 Regist	rar's Signature	neds s		1		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM 9 PER FH G884 10-23-08 VT
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No./ 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 08 ances /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Markey len 9 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace Country) NC. Funeral Hours Min. Months Days 1 □ M 2 🚺 18 9 Director 456 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show or items 23a or 28a-f showing the monthly of 1 □Yes 2√□No Director Glen Burnie MD Anne Arundel within 72 hours after death with the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 7575 East Howard Road 21060 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐Xever Married 2 ☐ Married Baltimore, Maryland 21215-0036 6 1 ☐Yes 2 No Specify other traumatic event, the Medical Exa-<u>م</u> 3 ☐ Widowed 4 ☐ Divorced "natural" Black Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within ; th and Mental Hygiene. **7 is marked other than "**! Elementary/Secondary (0-12) College (1-4or 5+) Private <u>Housekeeper</u> <u>8th grade</u> na 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Ments Important: If item 27 is marked any injury or other traumatic ev Chas. Huntley Frances Willoby ပ 19a, Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Moses McAllister 7575 East Howard Road, Glen Burnie, Md 21060 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☐ Burial 2 🙀 Cremation 3 ☐ Removal from State Greenmount Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 10/23/08 Baltimore, Md 21. Sign the of Funeral Service Licenses March F/H West 4300 Wabash Ave, Baltimore, Md 21215 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician 05 0 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine requires that the death certificate be executed burial-transit and Due to (or as a consequence of): physician as the burial Box 68760. Physician/Medical as ding IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? atten 3 Ectopic pregnancy õ Month Day Year 5 Other (specify) signed by the a ☐Yes 2 No P.O. 9 Dunknown 9 Unknowi Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed been a 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2 No 2 No 1 ☐ Yes 1 🗆 Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier cal (Check only one) and manner stated. To the I 29b. Signature and title of certifier 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registra

#### State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 11111 5/# /Medical 4c. County of Death Facility Name (If not institution, give street and number) City, Town or Location of Death Examiner 67 DI 6. Sex (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Min 1 ☐ M 2 💢 F Director **78** 11-11-1929 <u> 213–28–7390</u> Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Director MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral **421 McMECHEN STREET** 21217 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 ☐ Never Married 2 ☐ Married 0 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: BLACK 3 ₩ Widowed 4 □ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HOUSEKEEPER HEALTH other traumatic event, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Health and Mental ၉ JAMES W. SEARS NANCY L. BENTLEY 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CLANCY BROADNAX/SISTER 4010 EDGEWOOD RD. BALTIMORE, MD 21215 Department of Heal Important: If item 2 any Injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 1 ★Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE NATIONAL 10-27-08 BALTIMORE, MD 21. Signature of Funeral Service Licenses JAMES A. MORTON & SONS F.H., INC. tomes a 1701-31 LAURENS ST BALTIMORE, MD 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac, or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 1955 **Physician** 110 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially liet to differentially if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months 5 Other (specify) P.O. cate has been signed by the a page 2 should be detached to 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Fobably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 □ Yes 2 WNo 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 | Yes 2 | No Hospital: Other: 4 🗆 Nursing Home 1 Impatient 2 ER/Outpatient 3 DOA Certification: To 5 ☐ Residence 6 ☐ Other (Specify) this . Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Matural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident the Director: 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide 1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

3. Time of Death

VA

10d. Inside City Limits

Yes 2 No

Birthplace (State or Foreign Country)

 $\geq \infty$ 

Black, White, etc.

Month

1 ☐ Yes

29d. Date signed (Month, Day, Year)

Year

Day

2 No

Registrar

29b. Signature and title of certifie

30. Name and add

DHMH 17 Rev 1/2001

ath (Item 23a) (Type, Print)

32. Registrar's Signature

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Vear /Medical ctober 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Batimore Bayview Medical 9. Birthplace (State or Foreign Country) Funeral 1**M** M 2□ F Hours Director Usual Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at MD Completed by Funeral Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 146 222 ush filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 □ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify. Black 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DQ NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na any injury or other traumatic event. In acce. Elementary Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle) Be len ပ 19a. Informant's Name/Relationship Address (Street a Station, arver lurner Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crownsville, 10.23.08 21. Si pature of Fun (1) Service License ٧ац Nati Pilce 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Distress Syndreme **Physician** Respiratory **hours** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of): Box 68760. attending physician Physician/Medical the as asn yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery for t 3 Ectopic pregnancy in the past 12 months? Day Year Pregnant at time of death ned by the a □Yes 2□No 5 Other (specify) Records, P.O. 9 Unknown 9 Unknown signed by i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown 1 Yes 2 No page 2 should Completed has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate Division of Vital 1 □Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To After this Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1X Natural 5 Pending ithin 24 hours after death.

• the Funeral Director: Aft

• mpletely filled in by the fun investigation 1 ☐ Yes 2 ☐ No 2 Accident Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) rnulissa morganint RES - 000 OCTOBER, 21, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 EASTERN MELISSA MORGAN AVENUE, BALTIMORE, MARYLAND 21224 31. Date filed (Month, Day, Year) 32. Régistrar's Signature State Registrar 100 100 A

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 15 th 2008 Month 02 pm ise 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death ind HOHIMOVE Valdivia Date of Birth (Month, Day, 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 59 Days 1 M 2 F Months Hours Min 218-52-416 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County Baltimore 1 ☐ Yes 2 No MD 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number USA 2124 Valdivio 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Jack Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) State of MD Specialist 18years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) F. Hawkins DOCOTHI 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3701 Woodbine Ave. Apt. D Baltimore, Mb Z1215 KObin-Kane-Green Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State Greenmount Crematay 10-22-08 Baltimore, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Fundal Service Licensee Green effunera Srus 7281 iberty Rd. Randallstown, 411. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest clock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Acute Myccardial
Due to (or as a consequence of): disease or condition resulting in death) cardiomyopathy Von ischemic if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 3 □Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2**7** No 26. Place of Death (Check only one)

**Physician** /Medical Examiner certificate be executed burial-transit and

attending physician for use as the buria

signed by the a

has

certificate

After this

Physician

/Medical

Examiner

10a, State

**Funeral** 

Director

items 23a or 28a-f show ner must be notified at

traumatic event, the Medical Examiner must

Department of Health and Mental Hygiene, Important: If item 27 is marked other than any injury or other traumatic event, the Meone.

natural", or

Director

Funeral

þ

Completed

death with the Maryland

filed within 72 hours after

Baltimore, Maryland 21215-0036

Box 68760,

P.O.

Division or Vital Records,

Examine Physician/Medical ð Completed Be မ To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funera Certification:

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 【No 9 ☐ Unknown

27. Manner of Death

1 X Natural

2 Accident

3 ☐ Suicide

29a. Certifier

Medical

State

Registrar

4 Homicide

25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Hospital:

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury 28b. Time of (Month, Day Year) 5 Pending investigation

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

6 ☐ Could not be

29c. License number H45931 29d. Date signed (Month, Day, Year) October 16,2008

Dobrah 31. Date filed (Month, Day,

ZUU8

2835 32. Registrar's Signature



08-07860		Please Type or Print in B	ack Inde	lible In	(. Ensure	All Co	pies A	are Legii	Jie.	
Mary Carol Hende			/ Departm	nent of t cate of L	Tealth and	ivienta	пудк		. 9	008 3375
	ъ.	For State gistrar	Certific	cate of L	Jean -		2. D	Reg.	No.	3. Time of Death
Physician		Decedent's Name (First, Middle,Last)						lonth D ctober 19,	ay Year	0030 hrs
Medical Examine		Mary Carol Henderson			. City, Town, or I	Location of		Olobo, 101	4c. County of	Death
	4	<ul> <li>Facility Name (if not institution, give street and number University Hospital</li> </ul>	,		Baltimore				N	/A
			ge (In yrs. last b	oirthday)	If Under 1 Year	If Under	24Hrs. 8.	Date of Birth	MM/DD/YYYY)	g. Birthplace (State or Foreign
Funeral Director	- 1	21.6 / 0 2025	63	Yrs.	Months Days	Hours	Min.	12/07/		Country) Maryland
Director	l_	W_ZA		110.						
апу		sual Residence of Decedent  Oa. State 10b. County	10c. City, Tov	wn or Locatio	n					10d. Inside City Limits
		Maryland Anne Arundel Co	Pasa	adena						1 Yes 2 No
SOLE ne Maryland or 28a-f show fred at once.	Director	0e. Street and Number			10f. Zip Code			109	. Citizen of Wha	at Country?
or 2	븳	8492 Laurel Road			2112				<u>United</u>	States
with t		4 Marital Chatus 12 Was Decede	nt Ever in U.S.	13. Was	Decedent of His	spanic Origi	n? (Specif Puerto Rica	y Yes or No- an, etc.)	14. Race White	- American Indian, Black, , etc.
leath r iten	Funeral	1 Never Married 2 Married 1 Yes	2X No	1					Specify:	White
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	by F	Widowed 4 X Divorced If Yes, Give Year or Dates:			Yes 2 X No		ind of work	done	16b. Kind of Bus	siness/Industry
ours	훘	15. Decedent's Education (Specify only highest grade of		during mo	s Osual Occupa st of working life	e. DO NOT u	use retired)			
6 an "r	ig e	Elementary/Secondary (0-12) College (1-4 o	)F 5+)	Нот	emaker			15	Own	Home
303 withir jene.	Completed	12 yrs.  17. Father's Name (First, Middle, Last)	l_	поп	lemaker_	18.Mother's	s Name (Fi	rst, Middle, M	aiden Surname)	
filed I Hyg ed ott		Paul August				Vi	ola	Pononi		
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altimore, MD mit. Pages I and 2 sho spartment of Health and sportant; If item 27 is jury or other traumati		20a. Method of Disposition	20b. Pla	ace of Disposematory or other	ition (Name of ce	emetery,	C	Date	20c. Location -	City of Town, State
nore ages 1 at of F t; If		1 Burial 2 Cremation 3 Removal from	State	•	Mem. P	ark	10/27	7/2008	Glen	Burnie, MD
Itim ntmes ortan		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee		22. N	ame and Addres	ss of Facility	Sing1	eton F	uneral	& Cremation Srv
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aminer		or condition resulting in death)  Due to (or as a co	nsequence of):							1
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COF	冒	K						perfo 1  ✓ Yes	rmed? 2 No	death? 1 ✓ Yes 2 No
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Division of Vital Records, P.O. tal or Attending Physician: The law requires that the safter death. The properties of the this certificate has been signed by lied in by the funeral director, page 2 should be detack lied in by the funeral director, page 2 should be detack	<u>P</u>	1 V Yes 2 No 28a Date of	of Injury	28b. Time of	f Injury 28c. I	Injury at Wo	rk?	28d. Describe	how injury occi	urred
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isio	2	2 Accident Investigation 3 Suicide 6 X Could not be	of Injury - At ho	ome, farm, str	eet, factory, office	ce building,	etc.	28f. Location or Town,	(Street and Nur State)	nber or Rural Route Number, City
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Modical	29a. Certifier 1 Certifying Physician: To the best one) 2 Medical Examiner:On the basis of and manner st	f examination ar	nd/or investio	gation, in my opii	nion, death	occurred a	t the time, dat	e and place, an	gned (Month, Day, Year)
To To COT	2	29b. Signature and title of certifier				ense numb	er		1	22, 2008
		1 and the			0	.C.M.E.			October	
jok d.	1	30. Name and address of erson who completed caus	e of death (Item	1 23a)	4	D = W****	MD 04	201		
10 brug.		Jack Titus MD. Deputy Chief Medic			enn Street, I	baitimore	, IVID 21	1201		
	Stat	ST. Date filed (Month), Bay, real,	gistrar's Signatu	ure	med !					
Regi	stra	OCT 2 3 2008 B	MAN I	~ /9						riet

Certificate of Death

Physician /Medical **Examiner** 

**Funeral** Director

28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with to Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, If a Medical Experiments.

Baltimore, Maryland 21215-0036

**Physician** /Medical **Examiner** 

the Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760, P.0. Division of Vital Records, s certificate has the lirector, page 2 sl after death Director: within 24 hours aft

To the Funeral Di

completely filled in

Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death OCT. 20, 2008 Lucille Elizabeth Henderson 6:45 A. M 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death North Arundel Nursing & Rehab. Glen Burnie Anne Arundel County Social Security Number If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Months Days Hours 1 □ M 2X F 224-38-6027 95 Sept.27,1913 North Carolina Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 ☐ Yes 2X No Director Maryland | Anne Arundel Odenton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 604 Rolling Hill Walk #201 21113 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. ģ Specify: White 3 ₩ Widowed 4 □ Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Pau1 Barnes 2 Bertie 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alfred C. Henderson (son) 604 Rolling Hill Walk #201, Odenton, Maryland 21113 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 X Removal from State Rosewood MemorialPark Oct. 24'08 Virginia Beach, VA. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Rd. Baltimore, Maryland 21211 Mue 804 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 2 **X** No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4K Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ctober 21,2008 D-40521 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mahesh S. Ochaney, M.D. 325 Hospital Drive, Glen Burnie, Maryland 21061 31. Date filed (Month, Day, Year) 32 Registrar's Signature

Registrar DHMH 17 Rev 1/2001

State

OCT 23

2008

08-07816

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

dan	n Heide		State of Maryland / Department of Health and Mental Hy  1-For State  Certificate of Death		2008 3376
	Physici		Registrar	2. Date of Death	
Med	ical Exami		Adam Heid Adam George Heid	Month October 17	Day Year 0800 hrs 0800 hrs
ſ			4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Laurel		4c. County of Death Prince George's
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs.	8. Date of Birth	n(MM/DD/YYYY) 9. Birthplace (State or Foreign
	Director		547-84-6915   1 X M 2 F   57 Yrs.   Months   Days   Hours   Min.	AUG 19	
	any		10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
	and show nce.	5	MD Prince Georges Laurel		1 Yes 2 X No
	Maryla 28a-f d at o	Director	10e. Street and Number 10f. Zip Code	10	g. Citizen of What Country?
4	th the Maryland 23a or 28a-f sho notified at once.		124 Irving Street 20707	7 7	USA
•	ath wir	Funeral	11. Marital Status 1 Never Married 2 Married 2 Married 2 Married 2 Never Marri		14. Race - American Indian, Black, White, etc.
	ter des ", or i		1 X Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year Vietnam 1 Yes 2 X No specify:		Specify: White
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	21215-0036 21215-0036 Mental Hygiene. marked other than	임	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or R		ber, City or Town, State, Zip Code)
	MD d 2 sho lth and n 27 is aumati	-1	Erin Heid - daughter 626 Mankato Street, C	hula Vis	
			20a. Method of Disposition  1 Burial 2 X Cremation 3 Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
	Pages nent of ant: I		Metro Crematory, Inc. 10/2		,
	Baltimore, bermit. Pages 1 ar Department of Her Important: If ite		21. Signature of Funeral Service Liberage H. Williams 22 Name and Address of Facility Cremation Society 299 Frederick Road	of_Mary	land, Inc.
			23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or	d, Balti	imore, MD 21228 st, shock, or heart Approximate Interval
	Physician M. dical		failure. List only one cause on each line.		Between Onset and Death
	xaminer		Immediate Cause (Final disease or condition resulting in death)  a. Acute alcohol intoxication  Due to (or as a consequence of):		
			Sequentially list conditions, b.		
		ine	if any, leading to immediate Due to (or as a consequence of):		24
1	J sit	Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):		
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	Box 68760 e death certificate b the attending physi ed for use as the bu	sician/Me	IF FEMALE: 23c. If yes, outcome of pregnancy   2   2   2   2   2   2   2   2   2	incy	23d. Date of delivery  Month Day Year
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	Division of Vital Records, P.O. Box Hospital or Attending Physician: The law requires that the death 424 hours alter death. Funeral Director: After this certificate has been signed by the atteredy affect in by the funeral director, page 2 should be detached for use	Phys	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e Did to	bacco use contribute to the cause of death?
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	ords, P.C. w requires that as been signed ! should be deta	Completed		24a. Was a	
	COL law r has b e 2 sho	nple		autops	med? death?
ı	Vital Rec ysician: The l his certificate l director, page		25. Was case referred to medical 26.Place of Death (Check of D	1 Yes 2	2 No 1 Yes 2 No
	Vital hysician this cert directo	Be	examiner? Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other, Nursin		Residence 6 🗸 Other: Scene
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	ivisior or Attene after death Director:	ific	3 Suicide 6 X Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (S	Street and Number or Rural Route Number, City tate 24 Trving St.
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	Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and one) Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a	due to the cause at the time, date a	e(s) and manner as stated. and place, and due to the cause(s)
	To the within 2 To the complet	Medical	and manner stated.  29b. Signature and title of certifier  29c. License number		29d. Date signed (Month, Day, Year)
			O.C.M.E.		October 17, 2008
4			30. Name and address of person who completed cause of death (Item 23a)		
	<b>(</b> ()		Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21	201	

Registrar DHMH 17 Rev 1/2001 OCME 2006

State

31. Date filed (Manth Pay Year) 2008

7 Registrar's Signatur

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 10:30 P M Lillian D. Henry October 0 18, 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 2300 Dulaney Valley Road, #103F Timonium Baltimore Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Days 1 ☐ M 2 👿 F Months 215-12-4845 85 Jan 6, 1923 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Baltimore Timonium 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 2300 Dulaney Valley Road, #103F 21093 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: 3 X Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Donnelly Tarr Agnes 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen H. Rommel/Daughter 70 Oakway Road, Timonium, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 10/22/08 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Memorial Gardens Timonium, Maryland 21 of Fune Wervice Liceryee 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley Inc. 10 W. Padonia Road, Timonium, Maryland 21093 23a. Pa 1. Enter the disease, or complications stock, or heart failure. List only one cause Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (rinal resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II Other death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? No. 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 No 24a. Was an 20118M 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Injury at 28d. Describe how injury occurred Hospital: 2[No 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be

the death certificate be executed and P.O. Box 68760, attending physician for use as the buria or Vital Records, or Attending Physician: Division

signed by the a has page ? certificate After thi funeral

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

Be 2

**Funeral** 

Director

show

r than "natural", or Items 23a or 28a-f shov the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

within 72

1 and 2 should be filed w Health and Mental Hygien om 27 Is marked other th

permit. Pages 1 and 2.1 Department of Health an Important: If item 27 Is any Injury or other trau

**Physician** 

/Medical Examiner

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To the Funeral Director: Aft the Hospital

State

31. Date filed (Month, Day, Registrar

3 ☐ Suicide

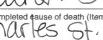
29a. Certifier

4 Momicide

(Check only one)

29b. Signature and title of certifier

determined



29c. License number

certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Item 23a) (Type, Print) 30. Name and address of

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Registrar's Signature

hysici		<ol> <li>Decedent's Nam</li> </ol>	e (First, Middle, Last	")					te of Death	Day	3. Time of Death
/Medic		CHZ	ARLES H.	HUTTON					onth cober 1	Day Year 2008	7:10P
xamir		4a. Facility Name (i	If not institution, give	street and number)		4b. City, To	own, or Location o	of Death		4c. County of Death	)
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neral		5. Social Security N	18	3.4 .05	yrs. last birthday, SYrs.	If Under 1   Months		Min. (M	te of Birth onth, Day, Ye	9. Birth	place (State or Forei intry)
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imporent; it tens 4 is marked other train. I having , or using 42s of 4sers and any injury or other treumatic event, the Medical Examiner must be notified at QDes.	Funeral Director	10e. Street and Nu				10f. Zip C			10g.	Citizen of What Cou	intry?
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SEE	ted		15. Decedent's Edu	ucation	16a, Dece	edent's Usual	Occupation		16b	. Kind of Business/li	ndustry
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ther		20a. Method of Dis	L. Rhodes,		b. Place of Disp	osition (Name	of	Derca		. Location - City or T	Town, State
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any ir		Elelle	u.P. 7	and le	н	arkins	Funeral	Home	Inc. I	Delta, PA	17314
		2/ a. Part Enter t shock, or hea	the disease, or comp int failure. List only o	lications that caused the one cause on each line.	death. Do not en	iter the mode	of dying, such as	cardiac or respi	iratory arrest,		Approximate Interval Between
ician	12.1	mediate Cause disease or condition	(Finat	Lun	- d	Cai	nce			1	Onset and Death
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

Physic /Med Exam

To the Hospital or Attending Physiclen: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

gistrar

3 2008

Dan

29b. Signature and title of certifier

31 Date filled (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type Print)

29c. License number

08-07885 Jol

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

L

hnnie Jones, Jr.	1-	For State	ate of N	Maryland /		tment of I ificate of I		d Mental H	lygiene <sub>Reg</sub>	2 0 . No.	08 3376
Physician	1.	. Decedent's Name (First, Midd	le,Last)						2. Date of Death	Day Year	3. Time of Death
Examine الم		Johnnie			A .	1.0	Jones	Jr_ Location of Deat	October 20,	2008	0648 hrs
	4	a. Facility Name (If not instituti 3619 Falls Road	on, give stre	et and number)		40	Baltimore	Location of Deat	1	4c. County of De	atn
Funeral	5.	. Social Security Number	6. Sex	7. Age	e (In yrs. la:	st birthday)	If Under 1 Year		_	(MM/DD/YYYY) 9. I	
Director	2	17-84-4187	1 X M	2 F	48	Yrs.	Months Days	Hours Mi	10 16		eign Country) DC
any	_	Sual Residence of Decedent  0a. State 10b. County		7	10c. City,	Town or Locatio	1		<u> </u>		10d. Inside City Limits
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r death with the Maryland or items 23a or 28a-f sh	1 era	Marital Status	12.	Was Decedent Armed Forces?	Ever in U.S		Decedent of His		Specify Yes or No- to Rican, etc.)	14. Race - Am White, etc	ierican Indian, Black,
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urs afte hural" mine	<u>a</u>  -	15. Decedent's Education (Sp	or D	ates:	npleted)	16a. Decedent's	Usual Occupat	tion (Give kind of		16b. Kind of Busine:	
72 hou	ĕ	Elementary/Secondary (0-12		College (1-4 or		during mo	st of working life	. DO NOT use re	etired)		41
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2121 uld be fi Mental I marked	<u>n</u>	Johnnie A.  9a. Informant's Name/Relation	Jones ship (Type,	Sr Print)		19b. Mailing	Address (Stree	Barbar et and Number o	Rural Route Numb	organ er, City or Town, St	ate, Zip Code)
MD 12 sho th and th and 27 is		Michael A.	Jones	-Broth		10890	Olde	Woods	Way, Co	lumbia,	Md 21044 or Town, State
S I and If Heal		20a. Method of Disposition  1 X Burial 2 Cremation	on 3 R	temoval from Sta		Place of Disposit rematory or other	on (Name of ce	metery,	Date	20c. Location - City	or Town, State
Page ment c	1	Donation 5 Other	Specify:		Men	orial_	Park _	110	/24/08	Landov	er, Md
Baltimore, MD 21215-0036  permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygione Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other transmite event, the Medical Examiner must be notified at once.	1	. Signature of Funeral Service	e Licensee	2		Mar	me and Address	West			
- Physician	2	23a. Part I. Enter the disease,	r complicati	ons that caused	the death.	Do not enter the	mode of dying,	such as cardiac	or respiratory arre	more, Most, shock, or heart	Approximate Interval
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Division of Vital Records, rat or Attending Physician: The law requints after death.  al Director: After this certificate has been s leed in by the funeral director, page 2 should the form.	ertification:	3 Suicide 6 Co	uld not be		njury - At ho	ome, farm, stree	t, factory, office	building, etc.	28f. Location (S or Town, Si		r Rural Route Number, City
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Division To the Hospital or Attendin within 24 hours after death To the Funeral Director: A completely filled in by the fil		(Check only one) 2 Medical E	aminer: On	the basis of exa manner stated	amination a	nd/or investigati	on, in my opinio	n, death occurre	d at the time, date	and place, and due	to the cause(s)
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6	3	<ol> <li>Name and address of pers Patricia Aronica-Pol</li> </ol>		oleted cause of Assistant I			111 Penn 9	treet Baltim	ore, MD 2120	1	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #20c State of Maryland / Department of Health and Mental Hygiene Per FH G884 10/23/08 JH Reg. No. 1 - For State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** 12:30 PM Anaela James 2008 10 18 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Randallstown Hospice-NW Baltimore easons If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 6. Sex Birthplace (State or Foreign Country) Year) 968 **Funeral** Days 1□ M 22 F Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location d other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be retified at 1 ☐ Yes 2 No Funeral Director MD Randallstown 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 2113 semere 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 □Yes 2 No Black Specify: Specify: ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Monee. College (1-4or 5+) ient Service Rep Financial Services tyears 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be 1 Health and Mental Brooks Holmes Wand ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Informant's Name/Relationship Rd. Husband 9503 Tulsemere Kandallstown, My 21133 Berald L. Baltimore, 20c. LSteelitoTryPatate 20a. Method of Disposition Date Pages 1 1 Burial 2 □ Cremation 3 □ Removal from State William Howard Day Conclet 10-25-08 Stechoum, PA
22. Name and Address of Facility Voughn C. Greene Suneral Sign. 4 □ Donation 5 □ Other (Specify) permit. 21. Signature of Funeral Service Licensee Randallstown, Mb21133 8728 Liberty Rd. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear railure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) failure Acute **Physician** /Medical Due to (or as a consequence of): Examiner Carcinoma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) Box 68760, physician Physician/Medical the attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day Pregnant at time of death 5 Other (specify) signed by the a I be detached f Ó 9 Unknown 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 🗌 Yes 2 No 3 Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No Deep venous 2200 Mont 24a. Was an has autopsy Hospital or Attending Physician: The certificate 2 2 No 1 ☐ Yes **Division of Vital** After this certific funeral director, | 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **☑** No 1∐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27, Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. To the P within 2: To the P 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature title of certifier F EEE E 2000 10/18/08

State Registrar 31. Date filed (Month, Day, Year)

OCT

Sen \$ 200

Main St

32. Registrar's Signatur

Reisters town, Md 21136

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

23

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #20b&c Per FH G884 10/27/08 JH State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year JONES Month 11:48 PM **Physician** HORACE TAMES 15 2008 10 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** BALTIMORE CITY VA MEDICAL CENTER NIA BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Numbe 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Months 1**X** M 2□ F 12/16/1945 North Carolina 62 Director 212-48-3541 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Baltimore Directo Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21217 1920 Eutaw Place Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1X Yes 2 No If Yes, Give 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 2 No 1965 72 hours after 1 ▼ Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 □Yes 2 No 2 3 Widowed 4 Divorced Year or Dates 1969 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Mass Transit Bus Driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be file and Mental F Be Lucille ဥ Horace Jones 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a 1920 Eutaw Place, Baltimore, Maryland 21217 Patrice E. Chase (Fiance ) 20c. Location - City or Town, State 20b. Place of Disposition (Name of Arbutous'e Memorital lactark 20a Method of Disposition permit. Pages 1
Department of I
Important: If ite
any injury or of Baltimore 1 Durial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest Ceme, 10/24/2008 Swings Mills, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility The Derrick C. Jones F/H, P.A. 21. Signature of Funeral Serv 4611 Park Hgts. Ave., Baltimore, Maryland 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. CORONARY ARTERY DISEASE Immediate Cause (Final **Physician** resulting in death) / /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leafly ground cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to jor as a consequence of Examiner the death certificate be executed use as the burial-transi and Due to (or as a consequence of): Box 68760 physician Physician/Medical signed by the attending d be detached for use as IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) 0 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, 2 CONGESTIVE HEART FAILURE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed ISCHEMIC CARDIOMYOPATHY 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 □ Yes 2 XNo 1 ☐ Yes 2 No 25. Was case referred to medical examiner?

Yes 2 □ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA ဥ completely filled in by the funeral after death. 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: Division Attending Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined e Hospital or A 24 hours after e Funeral Direc 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier TIMOTHY CHIZMAR, MIS PHYSICIAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TIMETHY P. CHIZMAN, MD 10 NORTH GREENE STREET BAITIMORE MO 21201 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2008 Christine Caroline Jones Month Year 6:30 A **Physician** Oct.15 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Bluepoint Nursing Home 9. Birthplace (State or Foreign Country) 1926 Jamaica, WI 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Apr. 25, 6. Sex **Funeral** Months Days Hours 1 □ M 2 🖫 F 215-76-2532 Director 82 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, fire Medical Examiner must be conflisted at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Maryland Yes 2 No Baltimore Director N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21215 Avenue Funeral 5106 Chalgrove 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 🌠 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Black 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired)

Nurses Alde Childrens Hospital 12th grade College (1-4or 5+) Fereil Mothers Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Reginald Beckford 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5106 Chalgrove Avenue Baltimore, Md 21215 19a. Informant's Name/Relationship (Type. Print) Kenneth Jones/ Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Greenmount Cemetery 0-23-08 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Rd Baltimore.Md 21215 Signature of Funeral Service Licensee Baltimore, Md 21215 23a. Part1 Enter the diseas , or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure, list only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ASCVD /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or njury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day 5 Other (specify) 2 NO □Yes Division of Vital Records, P.O. 9 D Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ğ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 ☐ Yes 2 ☐ No 1 □Yes 2 □Mo filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Dursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident To the Hospital or Attence within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 10/21/08 D0057465 P MSRajapahseMD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print).

N. S. RWAPAKSEMD 25 Main Street, Suite 200, Reisters town, MD, Z1136 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 3 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		_1	ricgistrai	<sub>7</sub> State of Mar	6884 /1092 Cei	artment of H 4/08 JH rtificate of L	ealth and N Death			33768
	Physicia		1. Decedent's Name (First, Middle, Last CHARLOTTE	)	KANE			2. Date of Death Month October	Day Year	3. Time of Death  01:35P
	/Medic Examin	4.5	4a. Facility Name (If not institution, give	street and number)	TOTAL	4b. City, Town, or	Location of Death	October	4c. County of Death	1
			St. Joseph Nursi	-		Baltim If Under 1 Year	ore If Under 24 Hrs.	Date of Blob	Baltimore	
I	Funeral Director		212-03-9793	x 7. Age ☐M 2∏ F	(In yrs. last birthday) 98 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Oct 27,	Year) 9. Bill Co. 1909 I11	nplace (State or Foreign untry) inois
	land ow It		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	a-f sh	ctor	MD Baltimo	ore	Ва	1timore				1 ☐ Yes 2☐ No
	or 28 or 28 be not	ᅙ	10e. Street and Number			10f. Zip Code	228	10	g. Citizen of What Co USA	untry?
	eath v	Funeral	1222 Tugwell Driv	12. Was Decedent Ev	rer in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba		ecify Yes or No-	14. Race - Amer	
30	be filed within 72 hours after death with the Maryland Hylgiene. Hylgiene. Ad other than "natural", or items 23a or 28a-f show do other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Fun	1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	Armed Forces? 1		If Yes, specify Cuba 1 ☐ Yes 2 🙀 No	in, Mexican, Puerto Specify:	Hican, etc.)	Black, White	hite
15-0036	in 72 hou "natura I dical E	Completed	15. Decedent's Ed (Specify only highest grad	de completed)	(Give	dent's Usual Occupa kind of work done of DO NOT use retired	ation during most of work f)	king	16b. Kind of Business/	Industry
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D	be file Ital Hy id othe event,	Be	17. Father's Name (First, Middle, Last)					e (First, Middle, N	1	
Maryland	should by	2	Eddie Yorkshi  19a. Informant's Name/Relationship (7)		19b. Maili	na Address (Street		rtha Rey	no⊥us City or Town, State, 2	Zip Code)
<u>8</u>	s 1 and 2 should Health and Men tem 27 is marke other traumatic		Frank Pipkin/cou			,			apolis, MD	
altımore,	- T o e		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐  4 ☑ Donation 5 ☐ Other (Specify	Removal from State		osition (Name of matory or other place			20c. Location - City or	
Baltii	permit. Pag Department Important: I any Injury o	. 1	21. Signature of Funeral Service con	-	ctor S	2. Name and Addrest tate Anato altimore,	omy Board	l 655 W.	Baltimore	Street
			23a. Part1. Enter the disease, or compshock or heart failure. List only	//	he death. Do not en	ter the mode of dyin	ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a	consequence of):	_			-	Lays
	Examiner		Sequentially list conditions	b	ittn'					year
	pe sit	iner	Sequentially list conditions, if any, leading to immediate cause. Ener Underlying Cause (Disease or injury	Due to (or as a	consequence of):				13	
20,	icate be executed physician and s the burial-transit	al Examiner	that initiated events resulting in death) Last	cDue to (or as a	consequence of):					
68760,		edical		d		-				
Records, P.O. Box (	The law requires that the death certifiate has been signed by the attending tage 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome p 1 □ Live birth 2 4 □ Pregnant at 9 □ Unknown	2 ☐ Fetal death 3	□Ectopic pregnanc □ Other <i>(specify)</i> _	у		23d. Date of de Month	livery Day Year
ds, P.	signed by d be detac	ρ	Part II. Other significant conditions of	ontributing to death bu	t not resulting in the	underlying cause giv	en in Part I.		oacco use contribute to es 2 ☐ No 3 ☐ P	o the cause of death?
Recor	The law requir cate has been si page 2 should l	Completed						24a. Was a autops perform	sy prior to med? death?	utopsy findings available completion of cause of
ţ		Be C	25. Was case referred to medical examiner?				26. Place of Dea	ath (Check only or		
× <	d <b>ing Physician;</b> T. After this certific funeral director,	ို	1 Yes 2 No		nt 2 ER/Outpatie		4 🔼 Nursing r		ence 6 Other (Spe	ecify)
uc	ding P	ion	27. Manner of Death  1 Natural 5 Pending  2 Accident investigation	28a. Date of Injur (Month, Day		Wo	rk?  Yes 2 □ No	200. Describe in	ow injury occurred	
Division or Vital	or Attending Physician; after death. Director; After this certifici in by the funeral director;	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined		ry - At home, farm, s . <i>(Specify)</i>	treet, factory, office	-	28f. Location (S City or Tow	treet and Number or R n, State)	ural Route Number,
	To the Hospital or Attent within 24 hours after death To the Funeral Director; completely filled in by the	Medical Ce	29a. Certifier (Check only one) 1	nysician: To the best on miner: On the basis of and manner sta	examination and/or	ath occurred at the ti investigation, in my	ime, date and plac opinion, death occ	e, and due to the durred at the time, d	cause(s) and manner a	s stated. e to the cause(s)
	To the vithin To the somple	Me	29b. Signature and title of certifier			29c. Licens	se number	2	29d. Date signed (Mon	th, Day, Year)
			· Charles R /slo.	fant		024	281		October 18	, 2008
					eath (Item 23a) (Type	e, Print)	000 80	muse	ms 2/225	
	St	ate	30. Name and address of person who Chaptes & GRAMAN 31. Date filed (Month, Day, Year)	32. registra	ar's Signature	Land 3	-3. ,	1		
	Regist		OCT 2.3	2008   200	1.0 h30 M	The state of the s				

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State of Maryland / Department of Health and Mental Hygiene

ıarı	k A. Lear		For State of Maryland / Department of the Certificate of De		Reg. N	. 20	08 3376
i	Physicia		Registrar 1. Decedent's Name (First, Middle,Last)		Date of Death     Month Day	/ Year	3. Time of Death 1331 hrs
/le	dical Examir		MARK ANDREW LEAR  4a. Facility Name (if not institution, give street and number) 4b. Ci	ty, Town, or Location of Death	October 17, 2	008 4c. County of Death	
K.		ĺ	4a. I donty Hamo (if not motional, give executive	altimore	25,34	,	
	Funeral		5. Godal Security Number	Under 1 Year   If Under 24Hrs	<b>─</b> `	M/DD/YYYY) 9. Birt Foreig	ın
	Director		214-72-0902 1XM 2F 48 Yrs.	onths Days Hours Min	03/03/1	960 Co	untry) MD
	any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
^	<b>*</b> .		MD Baltimore				1 X Yes 2 No
1	Vfaryland 28a-f show d at once.	Director	TID	. Zip Code	10g. (	Citizen of What Coul	ntry?
ñ	3a or	إة	3526 Roland Avenue	21211	S seif Ven en No	USA	ican Indian, Black,
1	th with	Funeral	1 X Never Married 2 Married Armed Forces? If Yes, s	cedent of Hispanic Origin? ( S pecify Cuban, Mexican, Puerto	o Rican, etc.)	White, etc.	ican indian, black,
	iter dez		o Widowoo	2 X No specify:		Specify: W	nite
	ours at atural	핡	during most of	sual Occupation (Give kind of f working life. DO NOT use re	work done 16i	b. Kind of Business/	Industry
	36 in 72 h han "r	plet	Elementary/Secondary (0-12) College (1-4 or 5+) 12 Manage	r		Car Deta	aling
	d with ygene other t	Completed	17. Father's Name (First, Middle, Last)		ne (First, Middle, Maid	en Surname)	
	215 be file antal H urked o	Be	David Sparks Lear III	Julie dress (Street and Number or	Wells	Cameron	
	MD 21215-0036 and 2 should be filed within 7 th and Mental Hygiene.  m 27 is marked other than aumatic event, the Medica	٩		Burrsville Ro			
	and 2 lealth item 2 traum	1	20a, Method of Disposition 20b. Place of Disposition	(Name of cemetery,	Date 20	oc. Location - City o	
	nore	- 1	1 Bural 2 Cremation 3 Removal from State Atlantic Cr	ematory 2	tober, 2, 2008	Glen Burni	ie, MD
	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	1	21. Signature of Funeral Service Licensee MOOQ 1.8 22. Name	and Address of Facility	ngleton Fu	meral & (	Cremation
		(	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the m	ices I /nd AV	enue 5.w.	GTEH DULL	Approximate Interval
	Physician		failure. List only one cause on each line.				Between Onset and Death
	taminer		Immediate Cause (Final disease or condition resulting in death)  a. Multiple drus (methad Due to (or as a consequence of): cloraze	pam) intoxicat	tion		
		<u></u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
		min	cause. Enter Underlying Cause (Disease or injury that initiated				
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	30x 68760, death certificate be executed he attending physician and of for use as the burial - transit	Physician/Medical Examiner	X UNPENDED AMENDED 23a,27,28a-f, p	erME, g885 11,	/6/08 TT		
	760, icate be ex physician the burial	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 2 Fetal of	death 3 Ectopic preg	anancy	23d. Date of delive Month	ery Day Year
	Box 687 e death certific the attending p	ician	past 12 months?  4 Pregnant at time of death 5 Other	(Specify)			
	of Vital Records, P.O. Box 6876 ing Physician: The law requires that the death certifical After this certificate has been signed by the attending plumeral director, page 2 should be detached for use as the	hysi	Part II. Other significant conditions contributing to death but not resulting in the under	arlying cause given in Part I	23e. Did toba	cco use contribute t	to the cause of death?
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	n of ding P After funera	uo:	27. Manner of Death  1 Natural 5 Pending 28a. Date of Injury (Month, Day, Year)  28b. Time of Injury (Month, Day, Year)	ry 28c. Injury at Work?  1 Yes 2 X No	unk	v agery december	
	Division of Vital Records, P.O Ital or Attending Physician: The law requires that the star death.  **All Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacted.	icati	2 Accident Investigation a Suicide 6 X Could not be 6 X Could not be		28f. Location (Str	eet and Number or	Rural Route Number, City
	Division of Vital F Hospital or Attending Physician: 24 hours after death: Femeral Director: After this certifi rely filled in by the funeral director,	Certification:	3 Suicide 6 A Could not be determined (Specify) House		Baltimor		
	Hos 24 h Fun tely			l at the time, date and place, a	and due to the cause(	s) and manner as st id place, and due to	tated. the cause(s)
	To the Hos within 24 h To the Fun completely	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.  29b. Signature and title of certifier	29c. License number		29d. Date signed (A	
	A	-	(140)	O.C.M.E.		October 18, 20	008
1	Ŭ		30. Name and address of person who completed cause of death (Item 23a)	<u> </u>			
			Ana Rubio MD. Assistant Medical Examiner 111 Penn Str	eet, Baltimore, MD 212	201		
	S Regis	tate	AAT A D DILLY ABBOARAGE A AST ABOAR	)			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 200 B Month **Physician** ALLISON MITCHELL 5:15 AM HLVEETA /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death NIA VERSSEN AVE ATTIMONE 1 Year If Under 24 Hrs. Days Hours Min. Social Security Number Age (In yrs. last birthday) If Under Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months Yea 1 M 2 F 214-54-9591 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Medical Exercite at must be redified at any injury or other traumatic event, it a Medical Exercite at must be redified at appear. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Ves 2 □No Funeral Director MD *more* 10g. Citizen of What Country? 10e. Street and Number 21206 Luerssen 4609 USA Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 2 100 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0.12) 2 Gollege (1-4or 5+) eceptionist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rollins Andrew M. Florence ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thaddeus P. Mitchell 4609 Lyerssen ave. Baltimore, MD 21206 20a. Method of Disposition Date Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Center 10-17-08 Elkridge,
22. Name and address of Facility Varyan C. Greener 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Van ld. 8728 Liberte Randa Mb 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** METASTATIC /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Due to (or as a consequence of): P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
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4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) ☐Yes 2 No certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 No 1 ☐ Yes eral Director: After this certifical filled in by the funeral director, I Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide within 24 hours a

To the Funeral I

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Registrar

State

227

32. Régistrar's Signature

Baltmorr

21203

Pince

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

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OGT

31. Date filed (Month, Day, Year)

Risebern

State of Maryland / Department of Health and Mental Hygiene 3377 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Vasi **Physician** October 16, 2008 5:20 Pm Rudolph Anthony Mannarino /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 17 W. Elm Avenue Baltimore 8. Date of Birth (Month, Day, Year)
Dec 15, 1924 If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1**∑**M 2□F 83 Director Pennsylvania 193-14-2108 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or itema 23a or 28a-f ehow the Medical Examinar must be notified at 1 √ Yes 2 No MD Director Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zio Code 17 W. Elm Avenue 21206 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 143-45 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: white Specify: à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ marked other than teacher education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Santo Mannarino Caterina Fiona 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eleanor W. Mannarino/spouse 17 W. Elm Avenue Baltimore, MD item 27 other tr 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State = 5 permit. Page Department of Important: If any injury or once. 4 X Donation 5 → Other (\$pecify) 21. Signature of Euneral Surver 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Director lengo Baltimore, MĎ 21201 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Due to (or as a consequence of): Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or): Examine Hospital or Attending Physician: The law requires that the death certificate be executed physicien and s the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical ettending pl IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year Month 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. is certificate has been signed by the director, page 2 should be detached 9□ Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No µeπormed? 1☐ Yes 2☑ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 , Pis After this funeral d 27. Man r of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation after death Director: / d in by the f 2 Accident 6 Could not be determined 3 Suicide 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funeral C completely filled i filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Tell Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 8048 10 20 08 30. Name an la dress of person who comp death (Item 23a) (Type Print) philadelphia Food #300 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** TONIA 10:42 M 2008 OCTOBER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** JOHNS HORKINS BAY VIEW MEDICAL CENTER BALTIMORE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** Months Min. Days Hours 1 □ M 2 🛛 F 214-50-3201 6-8-1947 Director 61 Italy Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show Lry or other traumatic event, it a Medical Eventing to neat the notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 √ Yes 2 No Baltimore Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. Funeral 21224 214 S. Conkling Street 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ※ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates: 1 □Yes 2 XNo Specify: Completed by 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 8th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gabriele Arcangela Tagliente Silvio ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Irma & Lucia Marangoni -</u> Conkling Street Balto. Md. 21224 permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr once. 214 S. 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Balto. Maryland Oaklawn Cemetery 10-25-08 Joseph N. Zannino Jr. Funeral Home 263 S. Conkling St. Balto. Md 2122 21. Signature of Funeral Service License Conkling St. Balto. Md 21224 23a. Part 1. Enter the disease, shock, or heart failure. Approximate Interval Between Onset and Death e, or mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest L't only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): Se. weeks /Medical **Examiner** neumonio Sequentially list conditions, if any, leading to immediate cause. Enter Uncertaing Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Muscular Dystrophy Myotonic attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 5 Other (specify) 9 Unknown 9 ☐ Unknown signed I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, à 2**N**0 3 Probably 4 Unknown 1 Tes page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No 1 ☐ Yes : After this certifications and director, p Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A
completely filled in by the fu investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MEDICALDOCTOR

DCTOBER, 22, 2008

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician DANIEL ERIC MULLINS 1556M 2008 toper /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** None altimore itimere re (ita 9. Birthplace (State or Foreign Country)
Maryland 8. Date of Birth (Month, Day, Year) 02/22/1963 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Funera! Months Days Hours 216-90-9040 45 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Experience must be neathed at XXYes 2 No Director Maryland None Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2201 Rogene Dr #202 21209 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □Yes 2XXNo Specify. White ₽ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry per nit. Pages 1 and 2 should be filed within 72.
Der artment of Health and Mental Hygiene.
Important: If Item 27 is marked other than "ne any injury or other traumatic event, I'm Media one. Elementary/Secondary (0-12) College (1-4or 5+) Executive Chef Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Richard Mullins Judith Ann Shaffer ೨ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2201 Rogene Drive #202 Baltimore, Maryland 21209 Aimee Janel Mullins Wife 20a. Method of Disposition
1 □ Burial 2 XX remation 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 3 Removal from State GreenMount Crematory 10/23/2008 Baltimore, Maryland 4 Donation 5 ☐ Other (Specify) 22. Name and Address of FacilitMitchell-Wiedefeld Funeral Home Inc nature of Funeral Service Licenses mis Sysken 6500 York Road Baltimore, MAryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** jear Kancreatic disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner the Hospital or Attending Physlcian: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical the IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death
Pregnant at time of death 3 🔲 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 25. Was case r erred to edical examiner? 1 ☐ Yes 1 TYes Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Spatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director; 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifier 2003 000 30. Name and address of person who completed cause of death (Item 23a) (Type Print) 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		For State of Ma		eartment of Health and ertificate of Death	Mental Hygier	2000 2277
Physicia	an	1. Decedent's Name (First, Middle, Last) Frances Hoffman Meginni	cc		2. Date of Death	3. Time of Death 9, 2008 8:22A M
/Medic Examin	al	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Dea		4c. County of Death
		Glen Meadows  5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday	Glen Arm  (i) If Under 1 Year   If Under 24 Hr	S P Date of Birth	Baltimore  9. Birthplace (State or Foreign
Funeral Director			39 Yrs.	Months Days Hours Mir		1919 Mary Tand
land bw		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or L	ocation		10d. Inside City Limits
e Mary ka-f sho	ctor	Maryland Baltimore	Glen Arm			1 ☐ Yes 2☐No
with the	Directo	10e. Street and Number 11630 Glen Arm Road		10f. Zip Code 21057	10g.	Citizen of What Country?
death	Funeral	12 Was Decedent E	ver in U.S. 13	. Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Pue	Specify Yes or No-	14. Race - American Indian, Black, White, etc.
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentall Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It a Medical Examination must be notified at once.	by Fu	11. Marrial Status  1 □ Never Married 2 □ Married  3. Whidowed 4 □ Divorced  1 □ Yes 2. Or Near Status  1 □ Yes 2. Or Near Status	0	1 □ Yes XXNo Specify:	,	Specify: White
72 hou natura		15. Decedent's Education (Specify only highest grade completed)	16a. Dec	edent's Usual Occupation e kind of work done during most of wo	orkina 1	b. Kind of Business/Industry
within lene. than "	Completed	Elementary/Secondary (0-12) College (1-4or 5-	-) life.	e kind of work done during most of wo DO NOT use retired) Homemaker		Own Home
e filed tal Hyg d other	Be C	17. Father's Name (First, Middle, Last) George F Hoffman			ame (First, Middle, Maid	den Surname)
hould to Ment marked matic e	၉	19a. Informant's Name/Relationship (Type. Print)	19h Mai		h Cherry	ity or Town, State, Zip Code) 20152
and 2 s ealth ar m 27 ls her trau				Mink Meadows St		
Pages 1 and tof He int; If Item		20a. Method of Disposition  1 ☐ Burial 2XXCremation 3 ☐ Removal from State		position (Name of ematory or other place)		: Location - City or Town, State
permit. Pa Departmer Important any injury		☐ Donation 5 ☐ Other (Specify)  2#/ \$ignature of Funeral Service Licenspe		unt Crematory Oct 22. Name and Address of Facility M	<u>'</u>	Baltimore, Maryland feld Funeral Home inc
g ggggg		Vennes Dushen Jon	Res)	6500 York Roa	ad Baltimor	e, Maryland 21212
Physician		23a. Part 1. Enter the diseas 4, or complications that caused shock, or heart failure. List only one cause on each lin Immediate Cause (Final			ac or respiratory arrest,	Approximate Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)  a. Du f (or as a	consequence of):	V Farlure disease	77.475	-
Examiner	-	Sequentially list conditions, if any leading to immediate	nsequence of):	disease		
cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last  b. Due to (or as cause. Enter Underlying cause. Created that the condition of t	V. T.			70
cate be executed physician and the burial-transit		resulting in death) Last Due to (or as a	consequence of):			
	fedical	d				1
eath certific attending p	ian/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of 1 ☐ Live birth	2 Fetal death 3	Ectopic pregnancy		23d. Date of delivery  Month Day Year
The law requires that the death certificate has been signed by the attending bage 2 should be detached for use as	Physician/Me	in the past 12 months?  1 ☐ Yes 2 DNo 4 ☐ Pregnant at 9 ☐ Unknown	time or death 5	Other (specify)		
ires that signed I	by	Part It Other significant conditions contributing to death but the significant conditions contributing to death but the significant conditions contributing to death but the significant conditions contributing to death but the significant conditions contributing to death but the significant conditions contributing to death but the significant conditions contributing to death but the significant conditions contributing to death but the significant conditions contributing to death but the significant conditions contributing to death but the significant conditions contributing to death but the significant conditions contributing to death but the significant conditions contributing to death but the significant conditions contributing to death but the significant conditions contributing to death but the significant conditions contributing the significant conditions contributing the significant conditions contributing the significant conditions contributing the significant conditions contributed the significant conditions contributed the significant conditions contributed the significant conditions conditions contributed the significant conditions contributed the significant conditions contributed the significant conditions contributed the significant conditions conditions contributed the significant conditions condi	t not resulting in the	underlying cause given in Part I.		co use contribute to the cause of death?
w requir s been s should	leted	Renal 12 Nuce			24a, Was an	24b. Were autopsy findings available
The law cate has page 2 :	Completed	Parkinsons disease			autopsy performed	prior to completion of cause of
Physiclan: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?		Othor: 1	eath (Check only one)	
_ D	n: To	27. Manuar of Death 28a. Date of Injur	nt 2 ER/Outpati y 28b. Time (Year) Injury	of 28c. Injury at	Home 5 Residence 28d. Describe how i	e 6 Other (Specify) injury occurred
Attending ir death. ector: After by the fune	catio	2 Accident investigation		M 1 □Yes 2 □No		
of or At after of Direct	Certification:	4 Homicide determined 28e. Place of Injurbuilding, etc	ry - At home, farm, s . (Specify)	treet, factory, office	City or Town, S	rt and Number or Rural Route Number, Pate)
To the Hospital or Attendinwithin 24 hours after death To the Funeral Director, After completely filled in by the fun	Medical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of and manner sta	examination and/or			
To th within To th	Me	29b. Signature and title of certifier	) mo	29c. License number <b>3 3 3 3 3</b>	D	Date signed (Month, Day, Year)  15 21, 2008
12		30. Name and address of person who completed cause of de	th (Item 23a) (Type	harus At Be	Winne	Ma 21204
Sta		31. Date filed (Month, Day, Year) 32. Registra	r's Signature			
Registr	ar	OCT 2 3 2008 A	And Angel	de l		

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Marie McWilliams Schoper 21. 200 /Medical Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 8. Date of Birth (Month, Day, Year) 02-23-1955 **Funeral** 1 □ M 2 ▼ F 53 Months Min. 213-64-0224 Maryland **Director** Usual Residence of Decedent 10c. City. Town or Location 10a State 10b. County 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Medical Exprehent rust be notified at Director 1 ☐ Yes 2X No Maryland Anne Arundel Co Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 21060 United States 2011 Norman Road items 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. rmed Forces? 72 hours after 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 ☐Yes 2√∑ No Specify. Completed by Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) tal Hygiene. Maryland 2121 Elementary/Secondary (0-12) 9 yrs. Board of Education College (1-4or 5+) Custodian yrs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Wilbur E. Studli Betty E. Cole ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sheila M. Summers / Daughter 2011 Norman Road Glen Burnie, Maryland 21060 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Pages Department of Important: If it any Injury or o one. 14 Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Mem. Park | 10/25/2008 | Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Singleton Funeral & Cremation Services; 1 2nd Ave SW, Glen Burnie, MD 2106 21. Signature of Funeral Service Licenses M01121 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** we lun Driene Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Tue to (or as a consequence of) attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 □ No 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 1 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. 28d. Describe how injury occurred Injury at Work? 1-Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No eral Director: / filled in by the f 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Price 31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Month Day **Physician** ROSALIE V. NOLAN 3:35 P<sup>M</sup> OCT. 19, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SPARROWS POINT BALTIMORE 7310 HUGHES AVE. If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Days Months 1 □ M 2 □XF Hours 218-05-2812 87 Director JAN. 4, 1921 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County d 2 should be filed within 72 hours after death with the Marylan th and Mental Hygiene.
7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Exprime must be notified at Director 1 ☐ Yes 2 No MD. BALTIMORE SPARROWS POINT 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 7310 HUGHES AVE. 21219 UNITED STATES Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🙀 No Specify. þ Specify: WHITE 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be GEORGE STEFFEN AGNES PLUCINSKI ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health an Important: If Item 27 Is r any Injury or other traur KEN THOMPSON/GRANDSON 7310 HUGHES AVE., SPARROWS POINT, MARYLAND 21219 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ATLANTIC CREMATORY 10/21/08 GLEN BURNIE, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CHARLES S. ZEILER & SON, INC. 6224 EASTERN AVE., BALTIMORE, MARYLAND 23a. Part 1. Enter the disease, shock, or heart failure. Approximate Interval Between Onset and Death complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Immediate Cause (Final **Physician** ARRHYTHMIA ARDIAC disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner OYEAR COLONARY DISEASE HRTERY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner YEAR HYPERTE MSION attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 more Year 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown THEROSCUEROSI Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy page performed? Yes 2 No 1 ☐ Yes 1 ☐ Yes 2 ☑ Mp 25. Was case referred to medical Be 26. Place of Death (Check only one. examiner? Hospital: Other: 4 Nursing Home 5 N Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27 Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: 2 Accident filled in by the 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

requires that the death certificate be executed Box 68760. o σ. Records, Division of Vital Physician: or Attending Hospital

altimore, Maryland 21215-0036

completely To the

State

Registrar

33407

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Seth

31. Date filed (Month, Day, Year) 2008

(Check only one)

29b. Signature and title of certifier



WISE AVE DUNDALK MD 21222

State of Maryland / Department of Health and Mental Hygiene 🤈 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician 6:50 A<sup>M</sup> Mary Belle Norris Oct 20, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner Montgomery County** Burtonsville Holy Cross Nursing Home If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 X F Director 85 <u>218-52-2512</u> May 3, 1923 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene.
Int: If Item 27 is marked other than "natural", or Items 23a or 28a-f show my or other traumatic event, the Medical Examiner must be notified at my or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Director Jessup MD Howard 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20794 U.S.A. 7904 Savage-Guilford RD. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Çuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify. þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Richard W. Thomas Maude Wright 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7902 permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other traonce. ilhord Kd Kobert Morris lebrip Mp 20b. Place of Disposition (Name of Cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Burial 2 ☐ Cremation 3 Removal from State 4 Donation 5 □ Other (Specify) Oct 23, 2008 Lisbon, Maryland True Gospel Cemetery Tre of Funeral Replice Licensed 22. Name and Address of Facility Part 1. Safer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) P **Physician** Pussi /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of) Frac Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 pronths? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9∏Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 | Yes 2 | No 3 | Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes ②☑ No 24a. Was an autopsy performed' 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4. ■ Nursing Home 5 □ Residence 6 □ Other (Specify) 1 ☐ Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA after death. Director: After this completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral I 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 120054566

State Registrar

9801 Cheorgia Avinu#1-17, Silverspring mozogo

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

avilli

32. Registrar's Signature

Bun Han Bho 9

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Year **Physician** 6-28 PM SHARON D. OLIVER 2008 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner TIMOR BALTIMORE CITY GOOD SAMARITAN If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months Days Year) Hours 1 □ M 2 🔀 44 212-84-7397 Yrs Director Oct. 24, 1963 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State Show d other than "natural", or items 23a or 28a-f showevent, the Medical Evantion or must be notified at Yes 2 No Director Maryland N/A Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 623 Glenwood Avenue 21212 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ∐Yes 2 XXNo Specify: Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cosmetologist Self-employed 12th grade year 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Johnnie Quill Gilmore Jerome A. Oliver, S 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Johnnie Quill Oliver/ Mother 623 Glenwood Ave Baltimore, Maryland 21212 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 10/22/08 ₩ Burial 2 Cremation 3 Removal from State Arbutus Memorial Park Arbutus, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityChatman-Harris FuneralHome 21. Signature of Funeral Service Licens 5240 Reisterstown Road Baltimore, Md 21215 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Imme i e Cause (Final di se or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner LITE MYCCARDIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit CORONARY and Due to (or as a consequence of): P.O. Box 68760. attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ð VENTRICULAR 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performe SYSTEMIC I LIPUS ERUTHEMATOR 1 Ves 2 1 No 25. Was case referred to medical examiner? Be 26. Place of Death heck only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ∐Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Magner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 1 M Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

State

Registrar

LOCH RAVEN BLUD, BALTIMORE, MD-21239

MEDICAL-RESIDENT

5601 LC 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

SULHITRA PARANJI

23

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Lashiya Nicole Porter Certificate of Death 1- For State Reg. No Registrar 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day October 16, 2008 1219 hrs Porter Medical Examiner Lashiya Nicole 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore** Johns Hopkins Bayview Medical Center 8. Date of Birth (MM/DD/YYYY) 9, Birthplace (State or if Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** Foreign Hours Min. Months Days Country) MD Director റാ 02 Vrs M 2 X F 214-17-8077 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 Yes 2 X No 28a-f show Harford Edgewood or items 23a or 28a-f sho must be notified at once. MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21040 U.S.A. 509 Arum Ct. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. Funeral 11. Marital Status White, etc. Armed Forces? 1 Never Married 2 Married mit. Pages I and 2 should be filed within 72 hours after dearment of Health and Mental Hygiene.

retant: If item 27 is marked other results. Yes 2 X No Yes 2 X No specify: Specify: Black f Yes Give Yee Widowed ≥ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) Wal-Mart Stock Manager na 12th grade 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lazette Holmes Be James Porter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Clydesdale Drive, York, PA 17402 605 Lazette Porter-Mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition Baltimore, crematory or other place) XBurial 2 Cremation 3 Memorial Park10/25/08 Woodlawn, Md Donation 5 Other Specify: 22. Name and Address of Facility nature of Funeral Service Licenses March F/H West Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Let only one cause on each line. 21215 Approximate Interval Between Onset and Physician Death Medical Morphine intoxication complicating acute asthmatic Immediate Cause (Final disease caminer or condition resulting in death) Due to (or as a consequence of): episode Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death certificate be executed Physician/Medical AMENDED 23,27,28a-f, per ME, g884 10/30/08 TT X UNPENDED attending physician or use as the burial 23d. Date of delivery Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE Year Month Day 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 ✔ Unknown g Unknown d by the a tached fo 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o Yes 2 No 3 Probably 4 ✔ Unknown þ ے Completed Division of Vital Records, 24b. Were autopsy findings available 24a Was an prior to completion of cause of autopsy performed? death? has 1 🗸 Yes ✓ Yes 2 certificate 26.Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certificompletely filled in by the funeral director, 25. Was case referred to medical Be Hospital: 1 Other examiner? Nursing Home 5 Residence 6 Inpatient 2 V ER/Outpatient 3 1 Yes ٩ 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Certification: Yes 2 X No undetermined Natural Pending 1125 hrs 10/16/08 Investigation 2 28f. Location (Street and Number or Rural Route Number, City Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc or Town, State)6401 Pulaski Hwy Baltimore, MD 3 6 X Could not be Suicide residence Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie October 17, 2008 O.C.M.E. 30. Name and address of person who completed cause of death (Item 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Zabiullah Ali, M.D. gistrar's Signatu 31. Date filed (Month, Day Year OCT 2

OCME

2008

State

Registrar

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 8 per fh g885 11-20-08 yt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deat Month **Physician** 200 Benedict A. Pokrywka /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 200 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) th yrs. last birthday 8 Date of Birth (Mo) Ht. D9/2/2ar) **Funeral** Months Hours Days **X**□M 2□ F Director 86 215-14-8275 Md. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f shov permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-1 shov any Injury or other traumatic event, It a Medical Examinat must be recitived at Md. BALTO. Parkville 1 □Yes 2X No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 8800 Walther Blvd. 21234 Usa Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 XYes 2 □ No Army If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Maryland 21215-003 þ Specify: White 3€ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Interstate Systems Elementary/Secondary (0-12) College (1-4or 5+) 12 <u>Civil Engineer</u> Balto. City 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Leon Pokrywka Mary Piscor ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gregory Pokrywka Son 3724 Thoroughbred Lane Owings Mills, Md. 21117 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10-25,2008 St. Stanislaus Balto. City 21. Signature of Funeral Service License 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Rd. Nottingham, Md.21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine and burial-tra law requires that the death certificate be exe Due to (or as a consequence of): Box 68760. attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy for in the past 12 months? Month Day Year Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No P.0. the 9 | Unknown 9 Unknown ģ signed be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an has page 2 certificate Division of Vital 1 ☐ Yes Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မှ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) he Hospital or Attending Pl n 24 hours after death. he Funeral Director: After ti pletely filled in by the funera Certification: 28b. Time of 28d. Describe how injury occurred After Injury at Work? 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mathem as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier completely (Check only one) within 2 29b. Signature and title of certifles 29c. License number 29d. Date signed (Month, Day, Year) OCTOBER 21, 2008 D63054 Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE, ND MIAJID CINA, 9000 FRANKLIN SOUNCE DR. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 5:15 AM 20,2008 thanie Uctobe 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Old Windsor Mills saltimore If Under 1 Year Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth Hours Min. Month, Day, 9. Birthplace (State or Foreign Country) Caroline 2, 1915 1 N 2 □ F 251-18-964 Months Days 92Yrs. October Carolina Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Wes 2 □ No Director indsor Hore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 2 124 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Yes 2 ☐ If Yes, Give Year or Dates: 2 No 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Black ģ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Shoremar parrows 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Şurname) mue 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21244 Windsor Mills daughter DICL Hnderson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 28 08 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest DWINGS Mills 10 21. Signature of Funeral Service Licenses 22. Name and Address of Facility tone Funera towell 1 ber 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ollenall (OYY Due to (or as a consequence of): LRONIC DASTRUCTIV Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE 23c. if yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? 1 □ Yes 2 🔼 No 25. Was case referred to medical examiner? 26. Place of Death (Check onl one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

**Physician** /Medical Examiner Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

with

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.

permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If Item 27 Is marked other that any lajury or other traumatic event, Item Once.

Be

Maryland 21215-0036

Baltimore,

Box 68760,

P.0.

Records,

of Vital

d other than "natural", or items 23a or 28a-f sho

The law requires that the death certificate be executed burial-transi attending physician and Physician/Medical the as use detached for the signed by page 2 should be Completed been : has certificate Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be Certification: To

\$

Medical

28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

27. Manner of Death 1 Natural 2 Accident 5 Pending investigation 3 ☐ Suicide

6 ☐ Could not be

3 2

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Location (Street and Number or Rural Route Number, City or Town, State)

29a, Certifier (Check only one)

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and little of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DRIVE #325, DWINGS MILLS ROSSROADS MI) 32 Registrar's Signature 31. Date filed (Month, Day, Year)

State Registrar

02

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2:53 PM FREDERICK october SHELTON 2008 /Medical 4a. Pacility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner a IMOVE) Number 6. Sex 1 **X** M 2 □ F 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Securit **Funeral** Months Days Hours Min 212-30-2855 Director 74 09-17-1934 MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any lipury or other traumatic event, It a Medical Executor must be notified an once. 10c. City, Town or Location 10d. Inside City Limits 10b. County 1. Yes 2 □ No Director MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 905 N. PAYSON STREET 21217 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: BLACK Specify: \$ 3 ☐ Widowed 4 █ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 3 College (1-4or 5+) Elementary/Secondary (0-12) CLAIMS CLERK SOCIAL SEC. ADM. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be **BROWN** HELEN SHELTON ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2842 OAKFORD AVENUE, BALTO., MD 21215 REV. ERIC WHEELER, SR/NEPHEW 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State KING MEMORIAL PK 10/28/2008 | BALTIMORE, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC ames 1701 LAURENS ST., BALTIMORE, MD 21217 CA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Arterioscleratic Vascular disease or condition resulting in death) Coronary Unknown /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence on law requires that the death certificate be executed and Due to (or as a consequence of) Box 68760, attending physician Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 1 ☐ Yes 2 ☐ No Ö the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ital Records, \$ Hypertension 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 1 □ Yes 2 □ 1 Tyes or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☐ No Medical Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attend within 24 hours after death To the Funeral Director: filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

Registrar DHMH 17 Rev 1/2001

State

(Check only

29b. Signature and title of certifier

31. Date filed (Month, Day,

Bergesm

Year)

genn 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Agnes Itospital
32. Registrar's Signature

A Comment

29c. License number

29d. Date signed (Month, Day, Year)

900 Caton Avenue Baltimore Mary lant

Amend #5, perFh g885 11/5/08 TT Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. (\_ 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2:45PM 2008 oct 20 /Medical 4a. Facility Name (If not institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 8628 Glen Hannah Windsor Mill Baltimore 5. Social Security Number 63 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** Min 1 □ M 2 🗶 F Months 215.30. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at Baltimore MD 1 ☐ Yes 2 No Windson Funeral Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 8628 Gen Hannah Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: Black Completed by 3 Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) GBMC Nursing ssistant 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Columbus temell Elizabeth ္ရ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21244 19a. Informant's Name/Relationship (Type. Print) 8628 Glen Hannah Court 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of h important: if ite any injury or ot once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, MP oudon 10/24/08 4 ☐ Donation 5 ☐ Other (Specify) permit. 22. Name and Address of Facility Vaugus C. Greene Fundral SVO 21. Signature of Funeral Service Licensee Randallstown MD 21133 an Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Parkissons Disease /Medical Due to (or as a consequence of): Examiner ADVANCED Unknown Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed physician a s the burial-t Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical signed by the attending p IF FEMALE: 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Nonknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 autopsy performed? 1 ☐ Yes 2 ☑ No 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation s after death.

I Director: A death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a

To the Funeral C

completely filled 29a. Certifier i 🗑 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 20059056 22 08 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MI Regal Ave Bolt Salvia 21217 Dulicet MO 1600 Nest 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 23 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** STEVENS 2047 2008 ateber /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner Baltimore City** The Johns Hopkins Hospital Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**2** M 2 □ F Hours Director Usual Residence of Decedent 10d. Inside City Limits 10b, County 10c. City, Town or Location 10a, State er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at ¥SYes 2 □ No Director 10e. Street and Number 10g. Citizen of What Country? 10. Zip-Code Apt. C112 19145 USA PATEWAY DR. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or ite any injury or other traumatic event, the Medical Examiner 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be STEVENS ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) GATEWAY DR. Apt. C112 Philadelphia, PA Stevens 3800 SR. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State EIGH 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility ttonce complications that caused the death. Do not enter the mode of dying, such as cardiac in respiratory arrest Approximate Interval Between Onset and Death 23a, Part I. Enter the disease, or shock, or heart failure. List only one cause on each line. Immediate Cause (Final Extreme 10 days Prematurit Physician disease or condition /Medical resulting in death) Due to (or as a consequence of): Examiner Newonzine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence) or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): attending physician a Box 68760 Physician/Medical IF FEMALE: ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year in the past 12 months? Pregnant at time of death 5 Other (specify) signed by the at id be detached f 2 No 9 Unknown Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown Distress\_ Syndrome page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate has 2 No Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Hospital: Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 1 ☐ Yes 2 No 1X Inpatient 2 ER/Outpatient 3 DOA မ After this Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: Injury 1 X Natural 5 Pending investigation 1 Yes 2 No death. 2 Accident filled in by the within 24 hours after death

To the Funeral Director: A 3 Suicide Could not be determined 28f. Location (Street end Number or Rural Route Number, 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

State Registrar

Crowder Bernadette 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

23 2008 OCT

29b. Signature and title of certifier

MD

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

600 North Wolfe St, Baltimore, MD, 21287

15 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Mant -17-2008 Physician 10:45 a John M. Sibiski, Jr. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Balto. City Harborside Harford Gdns If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthdav) **Funeral** 1 ∏ M 2 □ F Months Days 59 Director 218-46-2228 4-4-1949 Md Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 □Yes 2X No Kingsville permit. Pages 1 and 2 should be filed within 72 hours after death with the Mar. Department of Health and Mental Hyglene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f sh any injury or other traumatic event, the Medical Evantmer must be notified a once. Balto. Director Md. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21087 USA 5 Kings Glen Ct. 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∐Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Telephone Co. Systems Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John M. Sibiski, Sr. A. Marie Grouling ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5 Kings Glen Ct. Kingsville, Md. 21087 Patricia Sibiski Spouse 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donay 67 5 □ Other (Specific) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition Gardens of Faith 10-23-2008 Balto.City Fun ral ervio 22. Name and Address of Facility el ensee 21. Signatur Schimunek Funeral Home 9705 Belair Rd. Nottingham, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ENAL DISPASE Immediate Cause (Final STACHE EN D **Physician** /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician and street street Hospital or Attending Physician: The law requires that the death certificate be executed Exami Due to (or as a consequence of): Physician/Medical attending pl IF FEMALE: yes, outcome of pregnancy 23d, Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗆 Ectopic pregnancy Month Day 5 Other (specify) □Yes 2□No been signed by the should be detached 9 Tillnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by OBSTRUCTIVE MISERTE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 No 2 No 1 ☐ Yes 1 ☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Hospital: 2 NO 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes Medical Certification: To this 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 🗌 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Division of Vital Records, P.O. Box 68760, within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0060560 ompleted cause of death (Item 23a) (Type, Print) 30. Name and address of person who KIVER NECK PANICAT 201

State Registrar

31. Date filed (Month, Day, Year) 2008

29a ertifier

32. Registrar's Signature

12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-07901 State of Maryland / Department of Health and Mental Hygiene Francis McAttee Stewart Certificate of Death 1. For State Reg. No 3. Time of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day October 20, 2008 1705 hrs STEWART FRANCIS MacATEE Medical Examiner c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore County** Nottingham 9216 Ramblebrook Road If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) g. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number Country **Funeral** Days Months Hours 219-44-8620 07/28/1945 Maryland Director 1 XM 63 Usual Residence of Deceder 10d. Inside City Limits 10c. City, Town or Location 10b. Count 1 Yes 2xx No Nottingham Maryland Baltimore 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Titlen 27 is marked other than "natural", or items 23a or 28a-f sho are other transmatic event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21236 9216 Ramblebrook Road 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. Funeral Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces X Never Married 2 Married 2 XXNo Yes White Specify: If Yes. Give Yea Yes 2XX No specify: Divorced Widowed ģ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) Horse Racing/Racetracks Policeman 21215-0036 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Marie Sarah Quinn Ravmond Stewart (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) Baltimore, MD Bandon Court Timonium Maryland 21093 Michael Ward Cousin 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) Baltimore, Maryland Burial 2 XXCremation 3 Removal from State 10-22-2008 GreenMount Crematory tant: Donation 5 Other Specify 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc 21. Signature of Funeral Service Licensee 6500 York Road Baltimore, Maryland 21212 Approximate Interval the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest; shock, or heart Between Onset and **Physician** Mailure. List only one cause on each line Death Medical a, Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease caminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate Examine Cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and rsician/Medical AMENDED UNPENDED attending physician or use as the burial The law requires that the death certificate be 23d. Date of delivery Box 68760 23c. If yes, outcome of pregnancy IF FEMALE: Year Month Day 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown signed by the a 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions Records, P.O. Yes 2 No 3 Probably 4 Unknown þ Completed 24b. Were autopsy findings available 24a. Was an certificate has been prior to completion of cause of autopsy performed? death? Yes 1 1 Yes 2 раве 26. Place of Death (Check only one) 25. Was case referred to medical To the Hospital or Attending Physician: Be Division of Vital Other<sub>4</sub> Residence 6 V Other: Scene examiner? Hospital: 1 Nursing Home 5 FR/Outpatient 3 Inpatient 2 this 1 Yes No 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? After 27. Manner of Death Certification: 1 V Natural Yes 2 Pending Director: 24 hours after death. 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be or Town, State) 3 Suicide To the Funeral D determined (Specify) Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and title of certifie October 21, 2008 O.C.M.E IMD. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201

Registrar DHMH 17 Rev 1/2001

OCME 2006

State

Donna M. Vincenti, MD

Assistant Medical Examiner

32. Registrar's Signature

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	,,,		rtificate of		Reg	. No.20	8 (	33788
4	Dharisi		1. Decedent's Name (First, Middle, Last	•				2. Date of Death		Year	3. Time of Death
	Physicia Medic/		James Richard	Snyder					19, 20	08	3:20 p. M
9	Examin	er	4a. Facility Name (If not institution, give				or Location of Death		4c. County o		1 1
•		- 10	6421 S. Orchard 5. Social Security Number 6. Se		last birthdav)	Lint If Under 1 Year	hicum   If Under 24 Hrs.	8. Date of Birth	Anne		
	Funeral Director		202-16-9331 Usual Residence of Decedent	X M 2□F 80		Months Days	Hours Min.	July 14,	1928		lace (State or Foreign htry) nsylvania
	land ow		10a. State 10b. County	10c. Ci	ty, Town or Lo	cation				1	0d. Inside City Limits
	Man a-f sh ifled	tor	Maryland Anne Ar	undel Co.	Linthi	Lcum					1 ☐ Yes 2 💢 No
	th the or 28	)ire	10e. Street and Number			10f. Zip Code		10	g. Citizen of W	nat Cour	itry?
	ath w	rall	6421 S. Orchard		- I		21090				tates
036	should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural" or Items 23a or 28a-f show matic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 预 Yes 2 No 192 If Tes, Give Year or Dates: 192	10	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 No	Hispanic Origin? (Span, Mexican, Puert Specify:	pecity Yes or No- o Rican, etc.)		, White,	an Indian, etc. ite
215-0036	thin 72 ho e. an "natur Medical B	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed) College (1-4or 5+)	16a. Dece (Give life.	dent's Usual Occup kind of work done DO NOT use retire	pation during most of wor d)	king	6b. Kind of Bus	iness/Inc	dustry
7	ed wil ygien her th t, the	Con		5+	Sch	nool Teac			High		001
≧	be od o	Be	17. Father's Name (First, Middle, Last)  Jacob R. Snyder					ne <i>(First, Middle, M.</i> Rosanna - S	aiden Surname Stahley	')	
Š	d 2 should th and Men 7 is marke traumatic	우	19a. Informant's Name/Relationship (T	vpe. Print)	19b. Mailir	na Address (Street		ral Route Number,		State. Zio	Code)
	nd 2 satth au		Mrs. Clara L. Sny			S. Orcha		Linthicum			21090
e,	tges 1 and of Healt I tem 2.		20a. Method of Disposition	20b. I		sition (Name of matory or other pla			Oc. Location - C		wn, State
Ĕ	Pages ment of I ant: If ite ury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ⚠ Other (Specify	nemoval hom State	restlav	vn Mem. G	ardens. 1				
Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licens	M01121				ngleton Fi			
			23a. Part1. Enter the disease, or companies shock, or heart failure. List only of	lications that caused the deal	th. Do not ent	ter the mode of dyi	ng, such as cardiac	or respiratory arres	st,	Ĭ	Approximate Interval Between
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4	/Medical Examiner		resulting in death)	Due to (or as a consec	quence of):					4	)
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09/89	cate b	Medical		d						-	
×	certific ding p	/Me	IF FEMALE:	23c. If yes, outcome pf pregn	ancv				23d. Date	of dollars	
.C. Box	The law requires that the death certificate be executed the has been signed by the attending physician and age 2 should be detached for use as the burial-transit	Physician/	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of a 9 ☐ Unknown	al death 3[	⊒Ectopic pregnanc ☐ Other <i>(specify)</i> _	у		Mon		Day Year
J.	w requires that the de been signed by the should be detached		Part II. Other significant conditions co	ontributing to death but not res	sulting in the u	nderlying cause giv	ven in Part I.	23e. Did toba	cco use contri	bute to th	ne cause of death?
ros	quires an sign uid be	ed by						1 ☐ Yes	2 □ No	3 ☐ Prob	ably 4 Dunknown
Kecords,	has bee	Completed						24a. Was an autopsy	24b. W	ere auto	psy findings available mpletion of cause of
		Com						perform 1□ Yes 2	ed? de	eath?	2 □ No
VItal	Physician: The land this certificate had rail director, page	Be	25. Was case referred to medical examiner?	Hospital:		Ott	201	th (Check only one			
_	Z isir	٠ <u>.</u>	1 Yes 2 No	28a. Date of Injury	28b. Time o	II OLI DOX	4 🗆 Nursing n	ome 5 Resider 28d. Describe hov			y)
0	nding Fith. :: After e funer	ition	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	Wo	rk? ]Yes 2∐No		,,		
DIVISION	To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined	28e. Place of injury - At h building, etc. (Special	ome, farm, str fy)	eet, factory, office		28f. Location (Stre City or Town,	eet and Numbe State)	r or Rura	I Route Number,
	e Hospita 24 hours e Funera letely fille	Medical C	29a. Certifier (Check only one) Certifying Phyone) Certifying Phyone	/siclan: To the best of my kno iner: On the basis of examina and manner stated.	owledge, deat ation and/or in	h occurred at the ti	ime, date and place opinion, death occu	e, and due to the cau arred at the time, da	use(s) and mar te and place, a	ner as s nd due to	tated. the cause(s)
	To th within To th	Me	29b. Signature and title of certifier			29c. Licens		29	d. Date signed	(Month,	Day, Year)
			Mod	elowyce	<del></del>	7	-4053	4 8	etober	21,	2008
	12		30. Name and address of person who o	ompleted cause of death (Iter	m 23a) (Type,	Print) 325	KOSPIT	21 0 0 1 21 0 61	E A	117	E 208
	100	te	DQ. OMANES  31. Date filed (Month, Day, Year)	32. Registrar's Signi	SIEN	(SURNIE	- MD	21061			

Registrar

OCT 2 3 2008 Books As April

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician Day Virginia C. Suffern 19 2008 October 0 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Hospital Center Westminster Carrol1 If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** 1 □ M 2 💢 F Director 88 Maryland 220-03-3298 Aug 28, 1920 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County show ral", or items 23a or 28a-f shor Examiner must be putified at 1 ☐ Yes 2√∑ No Director MD Carrol1 Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1627 Old Taneytown Road 21157 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify þ Specify: white 3 Widowed 4 □ Divorced Year or Dates "natural" Completed traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Department of Health and Mental Hygiene Important: If item 27 is marked other than any Injury or other traumatic event, the Mode. Elementary/Secondary (0-12) College (1-4or 5+) 12 secretary insurance/real estate 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edith Mae Slonaker Harry J. Cashman ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1820 Ashley Drive Westminster, MD Linda Crabbs/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) Signatur of Filmeral Service Lie Ronald 5 22. Name and Address of Facility Board 655 W. Baltimore Street rector 21201 3221 Baltimore, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause un each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician pairs resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical signed by the attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Month Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 Yes 2 No 3 Probably 4 Unknown been si should l Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 s certificate had rector, page 2 autopsy performed? 1 ☐ Yes 2 ☐ No 2 🗆 No 1 ☐ Yes director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) funeral 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No r death. 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

OCT 2 3 2908

Herry

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

DHMH 17 Rev 1/2001

29c. License number

29d. Date signed (Month, Day, Year)

		•	1- For State of Maryland / Depart Certification	ment of Health and Micate of Death	lental Hygiene	008 33790
	Physici /Medic		1. Decedent's Name (First, Middle, Last)  Lawa Terry		2. Date of Death Month Day	Year 3. Time of Death
	Examin		Good Samarita- Huspital	b. City, Town, or Localion of Death Baltimere	4c.	County of Dealh
	Funeral Director			f Under 1 Year If Under 24 Hrs.  In In In In In In In In In In In In In I	8. Date of Birth (Month, Day, Year) July 25, 194	9. Birthplace (State or Foreign County)  Marylard
	Maryland -f show	tor	10a. State 10b. County 10c. City, Town or Locate Maryland N/A	Battino	re	10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	th with the 23a or 28a st be noti	Funeral Director	10e. Street and Number 1315 Datton Rd.	10f. Zip Code 2/234	10g. Citiz	zen of What Country? USA
980	be filed within 72 hours after death with the Maryland Hygiene. I have then "natural", or itams 23a or 28a-f show of other than "natural", or itams 23a or 28a-f show event. The Medical Examinating at	by	1 ☐ Never-Married 2 ☐ Married 1 ☐ Yes 2 ☐ No	s Decedent of Hispanic Origin? (Spes, specify Cuban, Mexican, Puerto Yes 2 No Specify:	Rican, etc.)	14. Race - American Indian, Black, While, etc. Specify: Block
21215-0036	filed within 72 ho Hygiene. ther than "natur int, the Medical	Completed	(Specify only highest grade completed) (Give kin life. DO	t's Usual Occupation d of work done during most of work NOT use retired)  Must ratio	ing	nd of Business/Industry Pley Refuge Service
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	nd 2 sith ar 11th ar 27 is trau		Kense Oreen -dangkoer 2708	Damascus Ct.	Battimore	Mayland 2/215
Baltimore,	Page nent o ant: If ury or			enatory 10/3	31/08 Cat	cation- by or Town, Slate  ONSVILLE Maryland
Bal	permit. Pag Department Important: any injury 6		Janes Janes 35	o II dollatell	e Baltimor	
	Medical Examiner	Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter I shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter uncerying Cause (Disease or injury that initiated events	or respiratory arrest,	finterval Between Onset and Death	
Box 68760,	The law requires that the death certificate be executed tie has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dicai	Due to (or as a consequence of):  d.  IF FEMALE: 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ec	topic pregnancy	2	23d. Date of delivery
P.O. B	that the deat ed by the attr detached for	Physician/Me		ther (specify)		Month Day Year
	w requires tha been signed I should be det	by	Part II. Other significant conditions contributing to death bul nol resulting in the unde	riying cause given in Part I.  O) RCL		se contribute to the cause of death?
Vital Records,		e Completed	Diobeset mellinh  25. Was case referred to medical	J 26 Place of Death	24a. Was an autopsy performed?  1 Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No
Division of Vi	To the Hospital or Attending Physician: whithin 24 hours after death after this certific to the Funeral Director: After this certific completely filled in by the funeral director,	Certification: To B	examiner?  1  Yes 2  Hospital: 1 Inpatient	3 DOA Other: 4 Nursing Ho 28c. Injury at Work? M 1 Yes 2 No	me 5 ☐ Residence 6 28d. Describe how in∤un	y occurred  d Number or Rural Route Number,
	he Hospit n 24 hours he Funera	Medical C	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death or continuous of the basis of examination and/or investigation and manner stated.	curred at the time, date and place, igation, in my opinion, death occurr	and due to the cause(s) ed at the time, date and	and manner as stated. place, and due to the cause(s)
•	To the within to the comp	Z	29b. Signature and title of certifier physics a	29c. License number H 005954		e signed (Month, Day, Year)  Der 2-, 200 8
2	7		30. Name and address of person who completed cause of death (Item 23a) (Type, Print 1 eres a mark DO 560	Loch Raven	Blvd. B	altimore, Maryland
	Sta Registr		31. Date filed (Month Day, Year) 2008 32. Registrar's Signature			0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** BUND 4:50 PM M Tough October 0 17, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Joseph Richey Hospice Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F Months Days Hours Min. unk Director Feb 28, 1956 192-40-2489 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b County ? Is marked other than "natural", or items 23a or 28a-f eho traumatic event, the "tecical Examiner must be notified at 1 ▼ Yes 2 No Director Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2766 Pelham Road 21213 Funeral unk 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🛱 No If Yes, Give Year or Dates: Specify: Specify: white ò 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation un 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) tal Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) unk unk 18. Mother's Name (First, Middle, Maiden Surname) unk 17. Father's Name (First, Middle, Last) Be ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Richey Hospice 828 N. Eutaw Street Baltimore, MD permit. Pages 1 and Department of Healt Importent: If Item 2' eny Injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5▼Other (Specify) in state Ronald S. Wave, State Anatomy Board 655 W. Baltimore Street Director Baltimore, MĎ 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** liver carcinoma disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Cirrhosis Sequentially list conditions, in cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of attending physician and for use as the bunal-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 T Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendle within 24 hours after death. To the Funeral Director: A 2 Accident completely filled in by the 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 301 ST PAUL BOUT MD 2002

DHMH 17 Rev 1/2001

State

Registrar

Francis 31. Date filed (Month, Day, Year)

OCT 2 3 2008

-08 Oate of Death

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dougls datelo-17-28

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] [] S Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Ramesh Kalidas Vaidya October 2008 11:05 A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 10035 Clue Drive Bethesda Montgomery Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Days 1 X M 2 □ F Hours 66 India 579-68-3589 02-04-1942 Gujarat, Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2\\ No MD Montgomery Bethesda 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 10035 Clue Drive 20817 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐Yes 2X No Specify 3 Widowed 4 Divorced Asian Indian 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) U. S. Government 6 Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Kalidas J. Vaidya Shantaben Vaidya 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10035 Clue Drive Bethesda, Maryland 20817 Sandip R. Vaidya / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🛱 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arundel Crematory | 10-20-2008 Odenton, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Donaldson Funeral Home & Crematory, P.A 1411 Annapolis Road Odenton, Maryland 21113 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Amyotrophic Lateral Sclerosis Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year

Physician /Medical Examiner

permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any Injury or other trau once.

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

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**Funeral** 

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene. Intent of Heath and Mental Hygiene. Intent If item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the "Modical Exprintment and the notified at my or other traumatic event, the "Modical Exprintment and the notified at

Baltimore, Maryland 21215-0036

attending physician and for use as the burial-trar cate has been signed by the a page 2 should be detached to certificate funeral dir

The law requires that the death certificate be executed To the Hospital or Attending Physician: Within 24 hours after death.

To the Funeral Director; After this certified ours after death.

neral Director; A
filled in by the fu

Division of Vital Records, P.O. Box 68760,

Examine Physician/Medical Completed 25. Was case referred to medical examiner? Be 27, Manner of Death

Certification: To Medical

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? □Yes 2□No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 ☐ Yes 2 💹 No

1 X Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

4 ☐ Pregnant at time of death 9 ☐ Unknown

5 Other (specify)

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24a. Was an autopsy perform 1 ☐ Yes 2 🔽 No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

23e. Did tobacco use contribute to the cause of death?

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

October 18, 2008

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check/only 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

D0064615

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Genevieve Wroblewski, M.D. 1355 Taccard Drive Rockville, Maryland 20850 31. Date filed (Month, Day, Year)

State Registrar

completely

OCT 23 2008

5 ☐ Pending investigation

6 Could not be determined



an

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

**ORIGINAL** 

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 3:30ª ™ 22 2008 cens 10 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** N/A Balto 6959 McClean Blvd Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7-11-1943 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours Min 1 ☐ M 2√2 F Yrs MD 217-40-5555 65 **Director** Usual Residence of Decedent 10d. Inside City Limits 10h. County 10c. City, Town or Location 10a. State 1 Yes 2 No N/A Baltimore MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21234 6959 McClean Blvd U S Α Funeral 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Tyes 2X No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 1 ☐ Yes XXNo Specify: Specify: þ Black 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) I2th grade College (1-4or 5+) Johns Hopkins Medical Records N/A Hospital 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Erma Bailey Thomas Eugene Webster 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) Balto, MD 21234 6959 McClean Blvd Regina Webster-Daughter Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10-23-08 Balto, MD Greenmount 22. Name and Address of Facility 21. Signature of Funeral Service Licensee March East F/H la ) cu 1101 E. North Avenue Balto, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** o mon /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to inimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): ner Exami Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗌 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 1 ☐Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy 1 ☐ Yes 2 🗷 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number

should be filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

be executed

law requires that the death certificate

Box 68760,

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Division of Vital Records,

Hospital or Attending Physician: The

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24 hours after death Funeral Director:

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If tiem 27 is ameried other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinating rust be notified at

State Registrar

31. Date filed (Month, Day, Year)

Culmes

29b. Signature and title of certifier

30. Name and address of person

Padgett MD

32. Registrar's Signature

who completed cause of death (Item 23a) (Type, Print)

5601 Lock

ORIGINAL

Raver Blud, Raltimore, Mo

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** October 20, Edward F. Wojnowski 2008 8:25 P, M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Hospice Center Towson Baltimore 9. Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 09/11/1919 **Funeral** Months Hours Min. **X**□M 2□F Davs 215-05-2227 89 Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at Director 1 ☐Yes 2 X No Maryland Lutherville Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 23a or With 21093 United States 31 Margate Road Funeral death \ items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status filed within 72 hours after 1 Never Married 2 Married 0. 1 ☐Yes 2 X No Specify: White 2 3 Widowed 4 Divorced naturai Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Is marked of pe Peter Wojnowski Katherine Kendreirska Pages 1 and 2 should ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. Michael Wojnowski - Son 27 Hathaway Road Lutherville, Maryland 21093 20b. Place of Disposition (Name of cemetery, crematory or other place)
HOLY ROSARY
CEMETERY 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 10/24/2008 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License David J. Weber Funeral Homes P.A. 401 S. Chester Street Baltimore, Maryland 21231 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** LIVER MONTHS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause, Unsease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-tran Due to (or as a consequence of): the death certificate be Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year signed by the at d be detached fo 5 Other (specify) ☐Yes 2☐No 9 Hlnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ASBESTOS EXPOSURE 1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown been si Completed PROSTATE CANCER 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an page 2 s has autopsy performed? 1 ☐ Yes 2 Z No this certificate Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 MOther (Specify) HOSPICE 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After 1 Natural 5 Pending investigation To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Af completely filled in by the ful 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certific D64395 OCTOBER 21, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6565 N CHARUS ST, SUITE 209 BALTIMONE. MD 21204

Registrar DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

P.O. Box 68760

of Vital Records,

Division

32. Registrar's Signature

State

DANIEUE DOBERMAN, MD

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND, ITEM#17perFH, 8886, 12/1/08 WS
State of Maryland Department of Health and Mental Hygiene

1tems 5,17 pr ffi, 8885, 12/1/08dhb
Certificate of Death

Reg. Nd.) | | | | | Amend Items 5,17 1 - For E Stete Registrer Reg. No.) 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death PIS WITHER SPOON 2000 **Physician** ONOPHOSE 9.50 PM ONNE /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Hospital Randallstown 5. 250 \$ 56 \$ 9 181 250 \$ 56 Drthwest 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Morlth, Day, State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Days Min 1 □ M 2 📉 F O OYrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location worde | 10d. Inside City Limits 17 is marked other than "natural", or items 23e or 28a-f shor traumatic event, the Medical Examinar must be notified at Baltimore Windson 1 ☐ Yes 2 No **Funeral Director** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? KDad VOSARS 8264 death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11 Maritat Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. Int: if Item 27 ie marked other than "naturali, or ite ☐Yes 2XNo f Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black Specify: Completed by 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b, Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Clerk Social Securit 12th ande years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Alva Davis ,Sr. Davis capers Edna ဂ္ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s
Department of Health ar
important: if item 27 ie
eny injury or other trau Road Windsor Mill, MD 21244 8264 Vosges CINDY Davis 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 

Burial 2 □ Cremation 3 □ Removal from State King Memorial Park Windsor Mill, MD 2008 10/24 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Vaugn C. Greene Funeral SICS 22. Name and Address of Facility h Randallstown MD 21133 8728 Libert Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate fnterval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ADVANCED CHROMC OBSTANCTIVE LUNG DISCHE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence ot): Division of Vital Records, P.O. Box 68760, Be Completed by Physician/Medical cate has been signed by the attending page 2 should be detached for use as IF FEMALE: 23c. tf yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ⋈ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part tl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? POLMONARY HYRERTENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Tyes funeral director. 25. Was case referred to medical 26. Place of Death | Check only one Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending within 24 hours after death. To the Funeral Director: A investigation М 1 TYes 2 No the 3 Suicide 6 Could not be Ptace of Injury - At home, farm, street, tactory, office building, etc. (Specify) 28t. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 | Homicide Hospital 15 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 054288 October 18 2008 Hugnilal Center. 30. Name and address of person who completed cause of death (ttem 23a) (Type, Print) Neutrwell 31. Date filed (Month, Day, Year, 32. Registrar's Signature State Registrar 2 3

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year 9:46PM ASE V WEEMS 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death GOOD SAWARITAN HOSPITAL BALTIMOR BALTIMIORE CITY 8. Date of Birth Month, Day, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 , 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Year) Months Days Hours Min 1 □ M 2 □ -22-3290 Marylan une Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 1 Yes 2 1 No tomore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number rive 101 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 10 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Black 3 ₩idowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NQT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 0 18. Mother's Name (First, Middle, Maiden, Surname) 17. Father's Name (First, Middle, Last) YOK 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2/23 daughter 1002 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Durial 2 Cremation 3 Removal from State Himore 4 Dopation 5 Dother (Specify) towe MU 2120 4600 23d. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac of respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2; ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy 1 □ yes 2 □ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 NO 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA

/Medical Examiner and burial-tran law requires that the death certificate be execu Box 68760. physician the as aftending use jo P.O. detached þ s been signed to should be deta Records, certificate has page 2 Hospital or Attending Physician: The Division of Vital director this After th funeral n 24 hours after death.

Re Funeral Director: A pletely filled in by the fu death.

Physician

/Medical

Examiner

**Funeral** 

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner is ust be notified at

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= 5 permit. Page Department of Important: If any Injury or once.

**Physician** 

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Completed

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Certification: To

27. Manner of Death

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

5 Pending investigation

6 Could not be determined

death with the Maryland

filed within 72 hours after

Maryland 21215-0036

Baltimore,

completely within 2.

the

Medical 29c. License numbe 29b. Signature and title of certifier . Name and address of person who completed cause of death (Item 23a) (Type, Print) BHAUNEET 5601 DCHRAVEN BOULEVARD Year) 31. Date filed (Month, Day, 32. Registrar's Signature State 23 Registrar

Date of Injury (Month, Day, Year)

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

BALTIMORE, MD-21239

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month October 22 01:15 A Wassin 2008 Ε. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Union Memorial Hospital If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. Date of Birth (Month, Day, Year) 11/17/1944 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday, 1 □ M 2 🕅 F 63 215-76-8046 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 XYes 2 □ No Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1651 E. Belvedere Avenue 21239 S. A. Apt #218 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc 1 ∐Yes 2 **M**o If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No Specify: Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Disabled Disabled 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Catherine Schmidt John Wassin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2410 Poplar Road Essex, Maryland 21221 Joyce Matoska (Sister) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 10/22/2008 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory Baltimore City, MD 21. Signature of Emperal Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Ess Essex, Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Asystole Due to (or as a consequence of): Failure to thrive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events seattless in death). Due to (or as a consequence of): Sepsis resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 4 Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1 □ Yes 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

/Medical Examiner certificate be executed physician and the burial-transit Box 68760, attending p P.0. ed by the detached signed by t Division of Vital Records. page 2 should has certificate ! To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

**Physician** 

/Medical

10a. State

Director

Funeral

2

Completed

Be

Examiner

Physician/Medical

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Completed

Be

2

Certification:

Medical

Examiner

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Machael Experiment, and the natified at once.

**Physician** 

Baltimore, Maryland 21215-0036

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 Mo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 1 ☐ Yes 27. Manner of Death 1 ☑ Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Belyansky AT2438946 F32 October, 22, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

BelyANsky Igor 31. Date filed (Month, Day, Year) 23

32 Registrar's Signature

Menorial Hospital, MD Union

		ŀ	For State Registrar		State	of Mary			rtmen <i>tificat</i>				ntai Hy	giene, Reg. No.S	711112	3	3799
	Dharaini		1. Decedent's Name (F	irst, Middle, Lasi	)				_			2	. Date of Dea		Year	.	me of Death
	Physici /Medic		MARY	WINIFF		BELL							OCTOB1	ER 8	2008		:23 Рм
	Examin	er	4a. Facility Name (If no FREDERIC)	_							Location	of Death			County of De		
	Funeral		Social Security Number				n yrs. last birt	thday)	If Under		If Under	24 Hrs. 8	. Date of Birt		REDER 9. B	irthplace (5	State or Foreign
	Director		578-18-9045		□ M 2 <b>/x</b> F	89	,	Yrs.	Months	Days	Hours	Min.	Date of Birt Month Da July 28,	1919	,	Maryla	end
	and		Usual Residence of Dec 10a. State 10	cedent b. County		10	c. City, Town	or Loc	ation							10d. Ins	ide City Limits
	Maryl F sho	to	Maryland	Frederick			Freder	rick								1 [	Yes 2XXNo
	or 28a	Director	10e. Street and Numbe	r					10f. Zip					10g. Citiz	en of What C	Country?	
	ath wil		591 Cawl	Ley Drive	3 <del>-</del> B						703				USA		
5-0036	should be filed within 72 hours after death with the Maryland and Mental Hygene. marked other than "natural", or items 23a or 28a-f show imatic event, the Medical Examiner must be notified at	d by Funeral	11. Marital Status 1 ☐ Never Married 3 ☑ Widowed 4 ☐		12. Was Dec Armed F 1 ☐ Yes If Yes, G Year or I	orces? 2 <b>XX</b> No live	in U.S.		Vas Deced Yes, spec □Yes 2		ispanic Or n, Mexica Specify		fy Yes or No- can, etc.)		<ol> <li>Race - An Black, Wh</li> <li>Specify:</li> </ol>		
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ylar	should be f and Mental s marked o numatic eve	일	J	John W.	Gre	er					Han	nah	V.	Carp	enter		
Maryland	S S S		19a. Informant's Name		•				•				Route Numbe Ck, Mar		Town, State,	_	
	t and 2 Health tem 27		Pamela S. Br 20a. Method of Disposit	ition	<del>-</del>	2	20b. Place of cemeter					Date			cation - City o		ate
Ē			★GBurial 2 ☐ C 4 ☐ Donation 5 ☐	remation 3 D F	Removal from	i State	Resurre		_			10/13/2	2008	Clin	ton, Mai	rvland	
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature tunera	al Service Vicens	9 <sup>e</sup>			22.	Name an	d Addres	s of Facili	ty Geo	- 1	Kalas	Funera:	_	
			23a. Part 1 Enter the d shock, or heart fa	disease, or compl	ications that	caused the	death. Do r	not ente	er the mod	e of dyin	g, such as	cardiac or r	respiratory a	rest,		Appro	oximate al Between
	Physician		Immediate Cause (Final disease or condition		a Ca	rd	1000	ul.	moi	nai	y	Fa	ilu	re		Onset	t and Death
	/Medical Examiner	ļ.	resulting in death)		Due to	(or as a co	nse uence d	of):	,	8	0 in	. 0					
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	ficate be executed physician and s the burial-transit	Examiner	Esquerdially list condition if any, leading to immediate. Enter Underlying Cause (Disease or injust that initiated events resulting in death) Last	iry	c												
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68760,	ificate g phys	edical			d												
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٠ <u>.</u>	w requires that the d been signed by the should be detached	by Ph	Part II. Other significar	nt conditions co	ntributing to	death but no	ot resulting in	the un	derlying ca	ause give	en in Part I		23e. Did to	obacco u	se contribute	to the caus	se of death?
ğ	equire sen sig ould b												1 🗆 \	es 2	] No 3	Probably	4 Donknown
		Completed											24a. Was autop perfo 1 □ Yes		24b. Were prior to death?	?	dings available on of cause of
	Physician: The rthis certificate hai director, page	Be c	25. Was case referred examiner?	100	lospital:	(marking)	0 ED/O			Othe	or:		Check only o		Day 12		
ō	Attending Physician: r death. ector: After this certific by the funeral director, I	n:To	27. Manner of Death		28a. Date		2 ER/Ou 28b. T	Time of		8c. Injury Work	4 LJ N		d. Describe l		Other (Sp	pecify)	
Ö	ending F eath. or: After he funera	atio	2 Accident	Pending investigation	(1010	nun, Day, re	ar) II	njury	М		r Yes 2□	No					
Division of	tal or Att rs after de al Directe ed in by t	Certification: To	3 ☐ Suicide 6 4 ☐ Homicide	Could not be determined	28e. Płac build	e of Injury - ding, etc. (S	At home, fai Specify)	rm, stre	et, factory	, office		28	f. Location (5 City or Tov		d Number or i	Rural Route	e Number,
Λ	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi	Medical	29a. Certifier 12 (Check only 2 one)	Certifying Phy Medical Exam	iner: On the	ne best of m basis of exa nner stated.	y knowledge amination an	e, death d/or inv	occurred restigation	at the tir , in my o	ne, date a pinion, de	nd place, an ath occurred	d due to the at the time,	cause(s) date and	and manner place, and d	as stated. ue to the ca	ause(s)
4	Vith Com	Σ	29b. Signature and title			m	9				number	11		29d. Date	e signed (Mo	nth, Day, Y	éar)
	, ,			RILLON						N 00	65	443		10	109/	108	
	4		30. Name and address Elena	Iariko	a MD	400	W 7th	St	reet	Fred	leric	k, Mar	yland	217	701		
	Sta Registr		34. Date filed (Month, E	1 0 2008	Su	Hegistrar's	Signature	hou	K.								

			1 - State of Maryland / State of Maryland /		ırtment <i>tificate</i>			and Me		ene 200	8 33800
	Physici	an	1. Decedent's Name (First, Middle, Last)						Date of Death Month	Day Year	3. Time of Death
	/Medic		June Veronica Anastasi						october		2:01 p M
	Examin	er	4a. Facility Name (If not institution, give street and number)  Southern MD Hospital Center		4b. City, To		ocation of	f Death		4c. County of De	
	Funeval		5. Social Security Number 6. Sex 7. Age (In yrs. last It	birthday)	Clin If Under 1		If Under 2	24 Hrs.   8.	Date of Birth	Prince G	
	Funeral Director		577-36-1809 1□M 2□XF 79	Yrs.		Days	Hours	Min,	Date of Birth (Month, Day,	(rear) (1929 Ne	rthplace (State or Foreign country)
	D		Usual Residence of Decedent							, 1323 110	WIOIR
	show	_	10a. State 10b. County 10c. City, To	wn or Loc	cation						10d. Inside City Limits
	8a-f	Director		ney							1 ☐ Yes 2 🛣 No
	ath with t		10e. Street and Number 18301 Georgia Avenue, #6		10f. Zip 0	832			109	g. Citizen of What C	ountry?
9036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Mariest Evanting must be notified at once.	d by Funeral	11. Marital Status  1 □ Never Married  2 □ Married  3 □ Widowed 4 ☑ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ☒ No If Yes, Give Year or Dates:		Vas Decede fYes, specif □Yes 2		panic Orig , Mexican, Specify:	gin? (Specif , Puerto Ric	y Yes or No- an, etc.)	14. Race - Am Black, Wh Specify:	
21215-0036	d within 72 h giene. er than "natu , the Mudies"	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	Sa. Deced (Give k life. D Mana	lent's Usual kind of work DO NOT use .ger	Occupat done du retired)	tion uring most	of working	16	6b. Kind of Busines Restaur	
pu	e file tal Hy d othe	Be (	17. Father's Name (First, Middle, Last)			1	18. Mother	r's Name <i>(F</i>	irst, Middle, Ma	aiden Surname)	
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Maryland	12 sh thand 7 is m traum									City or Town, State,	
<u>ئ</u>	1 and Healt em 2		Kelly A. Bonsby/Daughter  20a. Method of Disposition 20b. Place					Drive,		, MD 2083 Oc. Location - City of	
3altimore,	Pages ment of ant: If it ury or o				sition (Name natory or oth Heaven			_ Oct	. 11,	-	ing, Maryland
Balt	permit. Depart Import any inj		21. Signature of Funeral Service Licensee	Fr. 50	Name and ancis O Uni	Address vers	of Facility Colli	ins Fu Blvd.	neral l W., Si	Home Inc. lver Spri	ng, MD 20901
			23a. Part 1. Enter the disease, or complications that caused the death. D shock, or heart failure. List only one cause on each line.	o not ente	er the mode	of dying	, such as	cardiac or re	espiratory arres	st,	Approximate Interval Between
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	/Medical Examiner		resulting in death)  Due to (or as a donsequence	-		30	33				
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\$	ate be executed hysician and the burial-transit	Examiner	that initiated events resulting in death) Last c	e of):							
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89	rtifica ng ph as th	Jed.	IS SEMALE.								
P.O. Box 68	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  Within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death		Ectopic pre Other (spe					23d. Date of d Month	elivery Day Year
ds, P	uires that signed to d be deta	þ	Part II. Other significant conditions contributing to death but not resulting	-	nderlying cau	-	n in Part I.				to the cause of death?
S	w req	lete	orgestire heart failme,		91414			_	24a. Was an	24h Ware	autopsy findings available
Division of Vital Records,	<b>iysician:</b> The la iis certificate ha: director, page 2	Completed	J						autopsy performe	prior to death?	completion of cause of
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Divis	I or Atter after des Director I in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)	farm, stre	et, factory, o	office		28f.	Location (Stre City or Town,	eet and Number or I State)	Rural Route Number,
_	Hospita 24 hours Funeral tely fillec	edical Co	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowled 2 Medical Examiner: On the basis of examination and manner stead.	lge, death and/or inv	occurred a	t the time	e, date and inion, deat	d place, and th occurred	due to the car at the time, dat	use(s) and manner te and place, and di	as stated. ue to the cause(s)
:	Fo the vithin of the comple	Med	one) and manner stated.  29b. Signature and title of certifier		29c.	License	number		290	d. Date signed (Mo	nth, Day, Year)
	->-0		Mramen - IMD			D	6318	3			
	3		7 (30) (4 )	a) (Type, F	Print)					10/07/6 MORNIM	- AAD
	Sta	to	31. Date filed (Month, Day, Year)  32. Fegistrar's Signature.	303	2	KRI	HIL	KE	DAD ,C	LIMIN	٠١٧١٠
	Registr		30. Name and address of person who completed cause of death (Item 23a VI) AV CHP LANDON 7 31. Date filed (Month, Day, Year) 32. Tegistrar's Signature OCT 0 9 2008	P	SHEL						

State of Maryland / Department of Health and Mental Hygiene 2 33801 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October 3. **Physician** Alsop-Williams 4:20A. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Hillhaven Assisted Lvg. Nursing and Rehab Ctr. Adelphi Prince George's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth Feb. 29, 1908 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 1 F Days Hours Min. 577-01-1014 100 Virginia Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, In Medical Eranical in the Instituted at 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Prince George's Hyattsville Funeral Director 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4407 Tuckerman Street 20782 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Be Completed by Specify: White 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas C. Poe Molly C. Gore 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maurice P. Alsop -son 4309 Vergie Avenue Beltsville, Maryland 20705 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State No Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery 10/8/2008 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, Maryland 21. Signature of Funeral Service Licenses Bonald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complicators that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Dementia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed tor: After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 X No 23d. Date of delivery 3 🔲 Ectopic pregnancy Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Stroke; Hypertension; Coronary Artery Disease 2 No 3 Probably 4 Unknown 1 🗌 Yes 24a Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 ZNO 2 XNO 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 X Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 10 D45217 October 3, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Adebowale Ajayi, M.D. 6201 Greenbelt Road, Suite U-15 College Park, Maryland 20740 31. Date filed (Month, Day, Year) . Registrar's Signature State 09 OCT Registrar 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

		-	State of Maryland / Dep	artment of Health and I rtificate of Death		0000 00000		
			- negistral	Tuncale of Death	Reg.	No. 2008 33802		
	Physicia	an	1. Decedent's Name (First, Middle, Last)		Month	Day Year In Co.		
	/Medic	al †	JOHN KALPH ABELL	the City Town or Leasting of Dooth		1 11, 2000		
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death St. Mary *s		
Ž.			St. Mary's Hospital  5. Social Security Number   6. Sex   7. Age (In yrs. last birthday)	Leonardtown  If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	Birthplace (State or Foreign		
	Funeral Director		220-34-8043 11√2 M 2□F 83 Yrs.	Months Days Hours Min.	(Month, Day, Ye	1925 Country) Maryland		
		1	Usual Residence of Decedent		nug. 3,			
	ylanc now	. [	10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits		
	a-fsl	ctor	Maryland St. Mary's Leonar	cdtown		1 □Yes 2 No		
	or 28	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?		
	th wil		22855 Cedar Lane Road	20650		USA		
	filed within 72 hours after death with the Maryland Hygiene. Uther than "ratural", or items 23a or 28a-f show ant, the Modical Even her must be retified at	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	<ol> <li>Race - American Indian, Black, White, etc.</li> </ol>		
36	afte , or it	by Fi	1 ☑ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give	1 ☐ Yes 2√ No Specify:		Specify:		
Ö	ural"	g p	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	edent's Usual Occupation	164	White  b. Kind of Business/Industry		
5	"nat	lete	(Specify only highest grade completed) (Giv	e kind of work done during most of wor DO NOT use retired)		. Nila di Busilless/illaustry		
72	withii ene. than	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	Farmer		Farm		
0	be filed ttal Hygi d other event, I		17. Father's Name (First, Middle, Last)		ne (First, Middle, Mai			
an		To Be	John Ralph Abell, Sr.	Pauli	.ne	Hayden		
Ž	should and Mer s marke umatic	F		ing Address (Street and Number or Ru	ıral Route Number, C			
Š	and 2 sealth a n 27 is	V		55 Cedar Lane Road	l, Leonard	town, MD 20650		
ē,	- I = =	P	20a. Method of Disposition 20b. Place of Disposition	osition (Name of ematory or other place)	Date 200	c. Location - City or Town, State		
Ê				ld-Echols 10/1	4/2008 Ch	narlotte Hall, MD		
Baltimore, Maryland 21215-0036	permit. Pag Department Important: I any Injury o		21. Si ratt le of uneral Service Lic rises	22. Name and Address of Facility Br		Funeral Home, P.A.		
	202 0		Edward N. Brinsfield, Jr M00052  23a. Part1. Enter the disease, or complications that caused the death. Do not en					
		27 D	shock, or heart failure. List only one cause on each line.	nor the mode of dying, odor do odraid.	or roophatory arrost	Interval Between Onset and Death		
A Comment	Physician		disease or condition a	HMIA		MIGHTES		
	/Medical Examiner		Due to (or as a consequence of):					
		io.	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):					
	ted nsit	in	Cause (Disease or injury					
	be executed sician and burial-transit	Examiner	that initiated events c					
8760	siciar buri	dical E	d					
687	ificate g physi is the k	edic						
Box	eath certific attending p for use as	Physician/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery		
m	d for	icia	in the past 12 months?  1	☐ Ectopic pregnancy ☐ Other (specify)		Month Day Year		
o.	res that the de signed by the a be detached t	hys	9 Unknown					
·.	s that med l	by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	cco use contribute to the cause of death?		
ğ	w require s been sig should b				1 ☐ Yes	2 No 3 Probably Unknown		
ပ္တ	s bee	Completed			24a. Was an	24b. Were autopsy findings available prior to completion of cause of		
m	The law te has age 2 s	E O			autopsy performe 1 □ Yes 2 🌡	d?   death?		
ta	an: rtifica tor, p	Be C	25. Was case referred to medical	26. Place of De	ath (Check only one)			
>	ysici is cel direc		examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ER/Outpati	ent 3 DOA Other: 4 Nursing H	lome 5 ☐ Residenc	ce 6 ☐ Other (Specify)		
0	g Ph ter th	i.	27. Manner of Death  28a. Date of Injury (Month, Day, Year)  28b. Time (Month, Day, Year)	of 28c. Injury at Work?	28d. Describe how	injury occurred		
<u>ō</u>	ath. nr: Af ne fur	atio	2 Accident investigation	M 1 □Yes 2 □No				
Division of Vital Records, P.	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Stree City or Town, S	on (Street and Number or Rural Route Number, r Town, State)		
	pital ours a eral C		29a. Certifier	ath occurred at the time, date and place	e and due to the cau	use(s) and manner as stated.		
	e Hos 124 hc e Fun	Medical	((Check only one)  2 Medical Examiner: On the basis of examination and/or and manner stated.					
	To th withir To th comp	Me	29b. Signature and title of certifier	29c. License number	29d	I. Date signed (Month, Day, Year)		
	Μ		MD	D0062667	2 0	Detober, 11, 2008		
	W.		30. Name and address of person who completed cause of death (Item 23a) (Type	e, Print)				
	1 10		THE CONTRACT OF THE CONTRACT O	OKOUT RD, LEONAL	Drown, MA	RYLAND		
	Sta		31. Date filed (Month, Day, Year)  32. Redistrar's Signature	Smark				
- 10	Regist	ar	OCT 1 4 2008					

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** October 6,  $P^{M}$ 2008 4:45 Hilda I. Beahm ∜Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel South River Health & Rehab Edgewater If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours 1 M 2 X F 1921 Virginia 87 Director 223-22-0980 June Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar more. 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 Yes 2 No Lothian Directo Maryland | Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20711 U.S.A. 6012 Cabin Creek Road Completed by Funeral 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yes 2X No Specify. 3 Nidowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Audrey Shepherd Luther Hicks P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) 6018 Cabin Creek Road, Lothian, MD John Beahm - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 N Burial 2 Cremation 3 Removal from State 10/11/2008 | Alexandria, VA Comfort Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility DEMAINE FUNERAL HOME 520 S. WASHINGTON STREET 21. Signature of Funeral Service Licensee Jana O AT FYANDRIA, VA 22314 enter the mode of dying, such as cardiac or Approximate Interval Between Onset and Death 23a. Part1. Inter the disease, or complications that caused shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed for use as the burial-transi to (or as a consequence of) Division or Vital Records, P.O. Box 68760. IF FEMALE: . If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 mont 1 Yes 2 No 9 Unknown Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2□No 26. Place of Death Check onl one 25. Was case referred to medical Be Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 25 No 1 🗀 Inpatient 2 ER/Outpatient 3□ DOA Medical Certification: To this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) Injury 1 Natural 2 Accident 5 ☐ Pending investigation ours after death.

neral Director; Af
filled in by the fur 1 ☐ Yes 2 ☐ No 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely 1 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier completed cause of death (Item 23a) (Type, Print) WASHINGTON RD, EDGEWATER, MD-21037 DHAWAN 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

**ORIGINAL** 

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# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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State of Maryland / Department of Health and Mental Hygiene Beth Anne Brown Certificate of Death Reg. No 1- For State 3. Time of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) October 5, Day 2008 ohysician/ 1553 hrs Examiner Beth Anne Brown 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Lanham Doctor's Community Hospital 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours VA 02/04/1969 39 Director 2 X F M 226-94-5466 Usual Residence of Decedent 10d, Inside City Limits Oc. City, Town or Location 10a. State 10b. County 1XXYes 2 No Prince George's Greenbelt MD s 23a or 28a-f shov e notified at once. 10g. Citizen of What Country? Directo 10f. Zip Code 10e. Street and Number USA 20770 7827 Jacobs Drive 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Funeral White etc. must be Armed Forces? 1 X Never Married 2 Married permit. Pages 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item injury or other traumatic event, the Medical Examiner must be injury or other traumatic event, the Medical Examiner must be 2 X No Yes Specify: Black Yes 2 X No specify. If Yes, Give Year Widowed Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done ğ 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Goddard Space Completed College (1-4 or 5+) Elementary/Secondary (0-12) Flight Center Astro Physicist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Frances <u>Blaney</u> Be Robert W. Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) Roanoke, <u>Virginia</u> NW 3110 Kershaw Rd, Frances B. Brown/Mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place)
Williams Memorial
Cemetery Itimore, 1 X Burial 2 Cremation 3 X Removal from State 10/11/2008 Roanoke, VA Donation 5 Other Specify 22. Name and Address of Facility Marshall's Funeral Home 21. Signature of Funeral Service Licensee Washington, DC 4217 9th STreet, NW 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and Death /sician failure. List only one cause on each line Medical Pulmonary Thromboembolism Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): b. Deep venous thrombosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examiner Enlarged uterus with numerous leiomyomata (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed put Physician/Medical AMENDED UNPENDED ding physician as as the burial -23d. Date of delivery Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE: Year Day 3 Ectopic pregnancy 23b. Was decedent pregnant in the Fetal death Live birth past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by ti o Yes 2 No 3 Probably 4 ✔ Unknown ۵ ۵. 24b. Were autopsy findings available Completed 24a, Was an Division of Vital Records, prior to completion of cause of peen page 2 should autopsy death? performed? has ✓ Yes 2 1 V Yes No After this certificate I funeral director, page 26.Place of Death (Check only one) 25. Was case referred to medical Hospital or Attending Physician: 24 hours after death. Be Other<sub>4</sub> Nursing Home 5 Residence 6 Hospital: 1 examiner? 2 PR/Outpatient 3 Inpatient 1 V Yes 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury 28a. Date of Injury (Month, Day, Year 27. Manner of Death Certification 1 Yes 2 No 1 V Natural Pending Funeral Director: stely filled in by the 28f. Location (Street and Number or Rural Route Number, City 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be 3 Suicide Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical To the 1 To the and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier October 6, 2008 10 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Ana Rubio MD. . Registrar's Signature 31. Date filed (Month, Day, Ygar) 2008 State

Registrar

		-	For State		artment of Heal <i>rtificate of Dea</i>			ne .No. 2008	33805	
		-1	Registrar  1. Decedent's Name (First, Middle, Last)		innoute or bet	1	2. Date of Death		3. Time of Death	
	Physicia	ın	Betty Virginia Bowles				Month	Month Day Year 10,15p		
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	<del></del> -	4b. City, Town, or Loca	ation of Death	4c. County of Death			
			Manor Care-Silver Spring			er Sprin		Montgo		
	Funeral		1□M 2□ E	yrs. last birthday) Yrs.		Under 24 Hrs. ours Min.	<ol><li>Date of Birth (Month, Day, Yo</li></ol>	ear) Cou	place (State or Foreign intry)	
a.	Director	-	231-34-7229 77  Usual Residence of Decedent	115.			April 11	, 1931 V	irginia	
	ow ot	ŀ		c. City, Town or Lo	ocation				10d. Inside City Limits	
:	mary i-f sh fied (	ţō	Maryland Howard	Colum	mbia				1 ∐Yes 2 🙀 No	
	n me	Directo	10e. Street and Number		10f. Zip Code		10g	. Citizen of What Cor	untry?	
	23a c		6324 Early Red Court		21045			USA		
92	should be filed within 72 hours after death with the Maryland nd Mental Hygiene. They marked other than "hatural", or Items 23a or 28a-f show marked other than "hatural", or Items 23a or 28a-f show imatic event, the Medical Examiner must be notified at	y Funeral	11. Marital Status  1 □ Never Married 2 □ Married  1 □ Yes 2 ☑ No If Yes, Give	1	Was Decedent of Hispan If Yes, specify Cuban, Manual of the Specify Cuban of the Specify Cuban of the Specific Cuban of the Specifi	nic Origin? (Spe lexican, Puerto I pecify:	cify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: Whi	, etc.	
5-0036	tural'	ed by	3₺ Widowed 4 □ Divorced Year or Dates:	16a. Dece	edent's Usual Occupation	1	16	b. Kind of Business/l		
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212	r thai	Completed	Elementary/Secondary (0-12) College (1-4or 5+)		Customer Se	ervice	I	ibrary of	Congress	
	e Kd al	To Be C	17. Father's Name (First, Middle, Last) Robert W. Pritchard		18.		(First, Middle, Ma 7 Flippo	iden Surname)		
	alth an 27 is 27 is r trat		19a. Informant's Name/Relationship (Type. Print)  Jennifer M. Bowles/Daughter		ing Address (Street and F 5324 Early F		*		, ,	
altimore,	0 0 <del>-</del> -		1 ☐ Burial 2 € Cremation 3 ☐ Removal from State		osition (Name of ematory or other place) itan Cremato	001	11.	c. Location - City or cexandria,		
Baltir	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licensee		2. Name and Address of	Facility Collins	Funeral	Home Inc.	ng, MD 20901	
<b>b</b>			23a. Part1. anter the disease, or complications that cauced the shock, or heart failure. List only one cause on each line.						Approximate Interval Between	
	Physician							- 5	Onset and Death	
<b>&gt;</b>	/Medical		disease or condition resulting in death)  a. Due to (or as a condition of the condition of	nsequence of):	viratory ular a	alles				
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	ecute and trans	Examiner	Cause (Disease or Injury that initiated events resulting in death) Last  Due to (or as a co							
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587	ficate phys s the	edical	d							
Vital Records, P.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the bunal-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome pf pregnant at time past 12 months? 4 □ Pregnant at time po □ Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of del Month	ivery Day Year	
صِّ	w requires that the di been signed by the should be detached		Part II. Other significant conditions contributing to death but n	ot resulting in the	underlying cause given in	n Part I.	23e. Did toba	cco use contribute to	the cause of death?	
g	quires n sigr ald be	d by	MTN, he of CUA	DH	Typed		1 □ Yes	2 No 3 Pr	obably 4 Unknown	
Reco	sician: The law ree s certificate has bee irector, page 2 shot	Completed	anemia, asp	ratio	on pneu	monia	performe	prior to (	utopsy findings available completion of cause of 2 No	
ta	iysician: The is certificate hα director, page	Be C	25. Was case referred to medical		26.	. Place of Death	(Check only one)	110 12100		
>	<u>&gt; .</u> . o	ToE	examiner? 1   Yes 2   No   Hospital: 1   Inpatient	2 ER/Outpatie			me 5 🗆 Residen	ce 6 □Other (Spe	cify)	
n o	ng Pl		27. Manner of Death 28a. Date of Injury 1 Natural 5 Pending (Month, Day Yo	ear) 28b. Time Injury	Work?		28d. Describe how	injury occurred		
Sio	tendi eath. tor A the fu	catio	2 Accident investigation	At home form		2 No	ORE Legation (Ctua	at and Muselman as Di	red Davida Alumbar	
<u>&gt;</u>	or Atterior fter death. Director / in by the f	Certification:	3 Suicide 6 Could not be determined 28e. Place of injury building, etc. (s	Specify)	treet, ractory, onice		City or Town,	et and Number or Ru State)	Irai Houte Number,	
C.Division or	To the Hospital or Attending Physician: within 24 hours after dealth and the Funeral Director After this certified completely filled in by the funeral director, is	edical Ce	29a. Certifier (Check only one)  1 Certifying Physician: To the best of n 2 Medical Examiner: On the basis of example and manner stated	amination and/or i	ath occurred at the time, of investigation, in my opinion	date and place, on, death occur	and due to the cau red at the time, dat	use(s) and manner as se and place, and due	s stated. e to the cause(s)	
	To the vithin or the omple	Mec			29c. License nu	ımber	290	I. Date signed (Mont	h, Day, Year)	
	1		> mull his	UX 14.	DI DO	0553	62	10-8-2	2008	
1	t		29b. Signature and title of certifier  30. Name and address of person who completed cause of death  21. Date filed (Month, Day, Year)  32. Jegistrar's	h (Itom 23a) (Type	Print) PR M	Eley	A H.D	Ka ser	permanente	
			31. Date filed (Month, Day, Year)  32. egistrar's	Clamator	# of 0					

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 10:47 pM Gayle Katherine Battiste October 06 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Montgomery Takoma Park If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** Days Months Hours Min. 1 □ M 2 🖾 F Director 524-10-3126 88 February 19,1920 Colorado Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10h County 10d. Inside City Limits or 28a-f show Examiner must be notified at Director Maryland Silver Spring Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene.
Int; If item 27 Is marked other than "natural", or items 23a or.) 1607 Moffet Road 20903 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify Specify Completed by 3 Widowed 4 Divorced Year or Dates White other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jasper Hunter Minnie Peterson 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) David Battiste - Son 34th Avenue, College Park, Maryland 20740 20b. Place of Disposition (Name of cemetery, crematory or other place, Baltimore Crematory at 20a. Method of Disposition Date 20c. Location - City or Town, State Department of H Important: If ite any Injury or of 1 Burial Z⊠Cremation 3 □ Rep oval from State 4 Donation ∕5 □ Other-(€pecif 10/10/2008 Baltimore, Maryland Loudon Park 22. Name and Address of Facility
Hines-Rinaldi Funeral Home, Inc.
11800 New Hampshire Avenue, Silver Spring, Maryland 20904 21. Sign ture of Juner a Service r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 23a. Part1. Enter the dise shock, or heart failure Immediate Cause (Final disease or condition resulting in death) Physician Sertic Shock (Sersis) 1 Month /Medical Due to (or as a consequence of) Examiner Clostridium Difficile Colitis 1 month Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Exami Due to (or as a consequence of) physician ar Division or Vital Records, P.O. Box 68760 Physician/Medical the IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 | Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 △ No Month Day 4□Pregnant at time of death 5 Other (specify) by the a 9☐Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Diabetes Type II, Hypertension, Subtotal Colectomy 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Atrial Fibrillation autopsy performed rector, page 2 1□ Yes 2 X No 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 1 🖾 Inpatient 2 ER/Outpatient 3 DOA Date of Injury 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Certification: 1 X Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🖸 Certifying Physican: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 2 ☐ Medical Examine and manner stated 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11120 New Hampshire Ave, Suite #305, Silver Spring Saed 31. Date filed (Month, Day, Year) OCT 0 9 32 Registrar's Signature State 2008 Registrar

		For State Registrar		artment of Health and N <i>rtificate of Death</i>		iene 2 ()	08 3380	
Physicia		1. Decedent's Name (First, Middle, Last)  Alan Charles Bewig			2. Date of Death Month October		3. Time of Death 1:00 A	
/Medic Examin		4a. Facility Name (If not institution, give stree 1292 Breckenridge C	*	4b. City, Town, or Location of Death Riva	<u> </u>	4c. County of		
Funeral Director		5. Social Security Number 6. Sex 218–68–8212	2□ F 7. Age (In yrs. last birthday) 54 Yrs.	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth (Month, Day, Aug. 22		9. Birthplace (State or Foreign Country) Maryland	
Aaryland f show	ĵo.	Usual Residence of Decedent  10a. State 10b. County  MD Anne Arund	el Riva	ocation			10d. Inside City Limits 1 □Yes 2♥No	
with the I a or 28a-	Direc	10e. Street and Number  1292 Breckenridge C	ii wala	10f. Zip Code <b>21140</b>	10	Og. Citizen of Wh	at Country?	
be filed within 72 hours after death with the Maryland filed within 72 hours after death with the Maryland Hygiene.  do other than "natural" or items 23a or 28a-f show event, it is in calculation.	by Funeral Director	11. Marital Status 12. 1 Married 2 Married 12. 1 Married	Was Decedent Ever in U.S. Armed Forces? I ∏Yes 2X No	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race -	14. Race - American Indian, Black, White, etc.	
within 72 horene.	Completed	15. Decedent's Education (Specify only highest grade contents)  Elementary/Secondary (0-12)	mpleted) (Give life.	edent's Usual Occupation kind of work done during most of work DO NOT use retired) The Manager		16b. Kind of Busi	·	
Janua L	To Be Co	17. Father's Name (First, Middle, Last)  Clarence Bewig	2 5001	18. Mother's Name	e (First, Middle, M cine Muth	faiden Surname)		
and 2 should I ealth and Men 27 is marke		19a. Informant's Name/Relationship (Type. Mary E. Clapsaddle/	Sister 705	ing Address (Street and Number or Rur Rusack Court Arno)	ld, MD 21	1012		
permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan Department of Health and Mental Hydene. Important: if the m27 is marked other traumatic event, its Modical Examinator and business and proces.		20a. Method of Disposition  1 Burial 2 □ Cremation 3 □ Reme 4 □ Donation 5 □ Other (Specify)  21. gnature Funeral Se e ens  23a. 9 rt1. 9 ter the disease, or o me catic shock or heart failure. List only one commediate Cause (Final disease or condition resulting in death)	Cemete  2 4  Ons that caused the death. Do not en ause on gach line.	Name and Address of Facility, P. 95 Gov. Ritchie Hw. ter the mode of dying, such as cardiac	A. Seven	Baltimo rma Park rma Park est.		
icate be executed physician and the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):	LOME CARRIO	100304 [	un 1018	ed YEARS	
	Physician/Medical	in the past 12 months?		☐ Ectopic pregnancy ☐ Other (specify)		23d. Date Mont	•	
w requires that been signed to should be deta	۵	Part    Other significant conditions contrib	uting tord dath but not resulting in the u	Inderlying cause given in Part I.	23e. Did tob 1 ☐ Ye 24a. Was ar	s 2 No 3	ute to the cause of death?  Probably 4 □ Unknown  ere autopsy findings available	
in: The la ifficate has or, page 2	e Completed	25. Was case referred to medical		00 0000 (0000)	autopsy perform 1 □ Yes 2	y pri ned? de Palvo 1	or to completion of cause of ath? □Yes No	
To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after decist.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Certification: To Be	examiner?  1   Yes   Yes   Yes    27. Manner of Death  1   Matural   5   Pending   2   Accident   investigation    28. Designation   6   Could not be	ital: 1 Inpatient 2 ER/Outpatie  18a. Date of Injury (Month, Day, Year)  18b. Place of Injury - At home, farm, st building, etc. (Specify)	of 28c. Injury at Work? M 1 □ Yes 2 □ No	ome 5 Reside 28d. Describe ho	ence 6 Other w injury occurred		
e Hospita n 24 hours e Funeral	edical C	29a. Certifier (Check only one)  Certifying Physicial Examiner:	an: To the best of my knowledge, dea On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, nvestigation, in my opinion, death occur	, and due to the ca red at the time, da	ause(s) and man ate and place, an	ner as stated. d due to the cause(s)	
To th withir To th comp	Me	29b. Signature and title of certifier	Apamo MI	29c. License number 66	29	9d. Date signed (	(Month, Day, Year) - 2006	
100		30. Name and address of person Myo comp	eted cause of death (Item 23a) (Type,	Print) 29- RIVA R	d #112	ANN	Apolis, UD	

State Registrar DHMH 17 Rev 1/2001 31. Date filed (Month, Day, Year)
OCT 0 7 2008

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month IO ď8ª Hugh Wesley Boyce 1745 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner WMHS Braddock Campus Cumber land Allegany 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, June 26 6. Sex 9. Birthplace (State or Foreign **Funeral** <sup>Year)</sup> 1924 Months Days Hours Min. West Virginia 216-18-1098 1⊠M 2∏ F Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Medical Examinar than the rediffed at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD. Allegany Director Westernport 1XXYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 237 **Dood** St. 21562 United States Funera! 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Specify: white Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Paper Manufacturer Elementary/Secondary (0-12) College (1-4or 5+) Operator unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Tom Boyce Ethel Sharpless ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carole Boyce/ wife 237 Wood St., Westernport, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place)
Philos Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 Period 2 Cremation 3 ☐ Removal from State Westernport Maryland 4 Donation 5 Dother (Specify) 2008 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Boal Funeral Home 111 Church St, Westernport, Maryland 21562 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ACUTE MYOCARDIAL INFARCTION TEN MINUTE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of). To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Dav 5 Other (specify) 1 □Yes 2 □No P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy performe 2 **Z**No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1∐Yes 2⊠No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation ours after death.

ieral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral I

completely filled 29a, Certifiei 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar DHMH 17 Rev 1/2001

State

29b. Signature a

JAMES R-MOEN.

31. Date filed (Month, Day, Year)

DJ3417 (MARYLAND)

1063 NATIONAL HIGHWAY LAVALE, MANYLAND

29d. Date signed (Month, Day, Year)

OCTUBER 14, 2003

21205

and manner stated

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

/Medical Examiner The law requires that the death certificate be executed physician and s the burial-transit Division or Vital Records, P.O. Box 68760 attending ph signed by d certificate has be irector, page 2 s To the Hospitai or Attending Physician: director, this

Physician

funeral After Director: within 24 hours after

To the Funeral Dire

completely filled in by

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r 28a-f show notified at

"natural", or items 23a or

Director

Funeral

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Examine

Physician/Medical

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Certification:

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31. Date filed (Month, Day, Year)

death with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If item 27 is marked other the any Injury or other trainers.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE 23b. Was decedent pregnant Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case derred to medical examiner? 27. Manner of Death Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) 432 October 1, 2004 Sto 106 lyper marlow the 20172

State Registrar

DHMH 17 Rev 1/2001

7611 S. OSBORNE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

32. Refestrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** Month Year 2158 PM otember 27 2008 /Medical 4a. Facility Name (If not institution, give street and number) Town, or Location of Death 4c. County of Death Examiner Social Security Number 6. Sex Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** Months Days Min 1∭ M 2□ F Director 160-36-9240 63 7/10/1945 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant: If item 27 Is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 ☐ Yes 2 XNo QUEEN ANNE'S Director MD SUDLERSVILLE 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 114 MILLER ST. 21668 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 14 Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced ear or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HEAVY EQUIPMENT OPERATOR CONSTRUCTION 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be SAMUEL HARDING BLAKENBILLER MARIAN EAMER ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JACQUELINE BLAKENBILLER/WIFE MILLER ST. SUDLERSVILLE, MD 21668 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION 10/3/2008 STEVENSVILLE, MD 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME
370 W. CYPRESS ST. MILLINGTON, MD 21651 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): ed by the attending physician detached for use as the burial Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Known 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Your nograms within 24 hours after death.

To the Funeral Director: After this certificate has t autopsy performed? 2 **341**0 or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☐ Mo Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Minpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 5 ☐ Pending investigation Injury 1 Anatural M 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) License number 29b. Signature and title of 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

ms

Tara

31. Date filed (Month, Day,

Year

0

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death October 8, 7:26 A М Clements William Gerald 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Prince George's Accokeek 139 Farmington Road West If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Nov. 5, 1916 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours Min. Months XX M 2 F Pennsylvania 579-12-2799 91 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10h County 1 ☐ Yes 2XXINo Director Accokeek Maryland Prince George's 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20607 USA 139 Farmington Road West Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? ★XYes 2 No 14. Race - American Indian, 11, Marital Status Black, White, etc. M⊠Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2XX Married White W II 1 ☐Yes 2XXNo Specify Specify: 2 3 ☐ Widowed 4 ☐ Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Mechanic Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Lest) Be Edna Pearl Beauchamp Charles Reginald Clements ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Adelta A. Clements / Wife 139 Farmington Road West Accokeek, Maryland 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State St. Mary's Ch. Cem. Clinton, Maryland 10/11/2008 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home P.A. ral Service Licens 6160 Oxon Hill Road Oxon Hill, Maryland 20745 Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Due to (or as a consequence of)

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show important: If item 27 is marked other than "natural", or items 23a or 28a-f show all night or other traumatic event, the Medical Evac instructs the molfilled at once.

Pages 1 and 2 should be filed within 72 hours after death with

Baltimore, Maryland 21215-0036

the Maryland

attending physician and for use as the burial-transit been signed by the should be detached

To the Hospital or Attending Physician: The law requires that the death certificate be executed After this certificate has funeral director, page 2: ours after death.
neral Director: A
v filled in by the fc within 24 hours a completely

Division of Vital Records, P.O. Box 68760,

SA

dical Exami	Cause (Disease or injury that initiated events resulting in death) Last	c	
Physician/Medica	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy  1	23d. Date of delivery Month Day Year
ģ	CHROWE OB.	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1 PYes 2 No 3 Probably 4 Unknown
Completed	DSTFOARTHRIT	75	24a. Was an autopsy autopsy performed?  1 □Yes 2 □ No 1 □ Yes 2 □ No 2 □ No
Be	25. Was case referred to medical examiner?	26. Place of Death	(Check only one)
2	1 Yes 2 No	Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA Other: 4   Nursing Hom	ne 5 Residence 6 Other (Specify)
ation: 1	27. Manner of Death  X∑ Natural 5 ☐ Pending 2 ☐ Accident investigatio	28a. Date of Injury (Month, Day, Year)       28b. Time of Injury M       28c. Injury at Work?       22 No         1       M       1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred
Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		Ref. Location (Street and Number or Rural Route Number, City or Town, State)
ical	29a. Certifier 1 CertifyIng Pl	nysician: To the best of my knowledge, death occurred at the time, date and place, a miner: On the basis of examination and/or investigation, in my opinion, death occurre	and due to the cause(s) and manner as stated. ed at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

#207 Waldorf, Maryland

State Registrar 31. Date filed (Month, 2008 DCT 0 9

29b. Signature and title of certifier



			For Stata Registrar		State of Ma	arylan	•			lealth a Death	and M	•	giene Reg. No.	2 H H Q	3381
	D		1. Decedent's Name	e (First, Middle, La:	st)							2. Date of De Month	ath Day	Year	3. Time of Death
	Physicia /Medic			Roge	r Frederick	C1axt	on					October			9:55 a M
May .	Examin		4a. Facility Name (/	f not institution, giv	e street and number)			4b. Cit		r Location o	of Death		4c.	County of Death	
Languar .				Hospice Ho						Airy	0.677			Freder	
	Funeral		5. Social Security N	1	ex 7. Ag ☑ M 2 ☐ F		last birthday) Yrs.	Month:	er 1 Year s Days	If Under	Min.	8. Date of Bir (Month, Da	th ay, Year)	9. Birth	nplace (State or Foreig untry)
	Director		220-38-4 Usual Residence of	4614		66	110.					October	3, 19	142 N	ew York
	land bw	1	10a. State	10b. County		10c. Cit	y, Town or Lo	ocation							10d. Inside City Limits
	Mary f sh	tor	Maryland	Anne Aru	nde1					Laurel					1 ∐Yes 2 🔀 No
	the rough	Director	10e. Street and Nur		1401			10f. Z	ip Code				10g. Citi	zen of What Cou	untry?
	3a ol	DE D	3507 Pir	neywoods Pla	ace, B-104					20724				U.S.	.A.
	ms 2	Funeral	11. Marital Status		12. Was Decedent	Ever in U.	S. 13.	Was Dec	edent of h	lispanic Ori	gin? (Spe	cify Yes or No Rican, etc.)	)-	14. Race - Amer	
9	or ite	F	1 Never Marri	ied 2 Married	Armed Forces? 1 ☑ Yes 2 ☐ If Yes, Give	No			2⊠No	Specify:		nican, etc.)		Black, White	, etc.
21215-0036	72 hours after death with the Maryland Inatural", or items 23a or 28a-f show disal Examinar must be notified at	d b	3 D Widowed	4 🖾 Divorced	Year or Dates:]	L962 <b>-</b> 1	964	1 🗆 103	22110	орсону.				Specify:	White
5-0	72 hc	Completed	(Spec	15. Decedent's Ed	lucation de completed)		16a. Dece (Give	dent's Us	ual Occup vork done	nation during most d)	t of workin	g	16b. Ki	nd of Business/I	ndustry
7	ithin ne. han "	ldm	Elementary/Seco		College (1-4or 5	i+)							77	41 0	
7	led w lygie her ti	ន		(F)	2		Nati	onal	Secur	Lty Age		/Eiret Middle		deral Gove	ernment
no	1 and 2 should be filed within Health and Mental Hygiene. em 27 Is marked other than "other traumatic event, In a Mental Health	8	17. Father's Name (First, Middle, Last)  Walter W. Claxton, Sr.  18. Mother's Name (First, Middle, Maiden Surname)  Edna M. Conley								Jumame)				
Š	narke	2		lter W. Cla			401 14-11		(044	and Alamaha				r Town, State, Z	(in Condo)
Mai	12 sh th and 7 Is n traun			ame/Relationship (											ip Code)
e,	Healt		Todd 20a. Method of Dis	R. Claxton	- Son	20h P						ate		nd 20871 ecation - City or 1	Town. State
وّ	iges If it		1₺ Burial 2	☐ Cremation 3 ☐	Removal from State	200.	Place of Disponentery, cre	matory or	other place	1					
Baltimore, Maryland	t. Partmel			5 ☐ Other (Specif		Gat	e of He			ery   ess of Facilit	10/09	/2008	Silve	er Spring	, Maryland
Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It a Madical Examinating must be notified at once.		21. Signature of Fu	uneral Service Licer	i O. Lo. t		1	Hines-	Rinalo	li Fune	ral Ho	ome, Inc			
			222 Part 1 Enter t	the disease or com	plications that caused	the deat								pring, Mai	ryland 20904
			shock, or hea	art failure. List only	one cause on each li	ne.	ii. Do not en	iter the m	oue or uyii	ng, such as	cardiac o	i respiratory a	irrest,	:	Approximate Interval Between Onset and Death
and a	Physician /Medical		Immediate Cause disease or condition resulting in death)	on	a. <u>Metastat</u>			Canc	er						
	Examiner		, and the second	•	Due to (or as	a conseq	uence of):								
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b.	Attending Physician: The law requires that the death certificate be executed crosent.  crosent.  ector. After this certificate has been signed by the attending physician and better this certificate be should be detached for use as the burial-transit.	Examiner	that initiated events resulting in death)	s Last	c Due to (or as	a conseq	uence of):								
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Box 6	ding Physiclan: The law requires that the death certific. h. After this certificate has been signed by the attending pl tuneral director, page 2 should be detached for use as t	Physician/Med	IF FEMALE: 23b. Was deceden	at pregnant	23c. If yes, outcome									23d. Date of deli	ivery
	eath atte	cial	in the past 12	months?	1 ☐ Live birth 4 ☐ Pregnant a			□ Ectopic □ Other (	pregnand specify) _	У				Month	Day Year
0	the cay the achec	ysi	9 ☐ Unknown		9 🗆 Unknown							- F-			
٠. ص	that ned b	by PI	Part II. Other signi	ficant conditions	ontributing to death b	out not res	ulting in the u	ınderlying	cause giv	en in Part I	•	23e. Did	tobacco ι	use contribute to	the cause of death?
rds	quires n sign ald be	q p										1 🗆	Yes 2	No 3□ Pr	obably 4 🗌 Unknow
00	w rec s bee shou	Completed										24a. Was		24b. Were au	topsy findings availabl
Re	he la e has ige 2	μď										auto perfo	ormed?	prior to death?	completion of cause of
a	ificat or, pa		25. Was case refer	rred to medical						OF Place	of Dooth	1 ☐ Yes (Check only		1 □ Yes	2 □ No
Division of Vital Records,	s cert lirect	o Be	examiner?		Hospital:	ent 2 🗆	ER/Outpatie	nt 3□I	DOA Oth	ori				6 X Other (Spec	cify) Hospice
of	JPhy erthi	n: T	27. Manner of Deat		28a. Date of Inji (Month, Da		28b. Time of		28c. Inju Wor			28d. Describe			nospice
on	th. : Afte	tio	1 ☒ Natural 2 ☐ Accident	5 Pending investigation		ay, Year)	Injury	M		K? Yes 2□	No				
<u> S</u>	Atter r dea sctor	ijij	3 Suicide	6 Could not be determined	Zoe. Flace of III	ury - At ho	ome, farm, st	reet, facto	ory, office		2	8f. Location	Street an	d Number or Ru	ıral Route Number,
Ö	al or s afte l Dire d in t	Certification: To	4  Homicide	20.011111100	building, el	ic. (Specif	y/					City or To	wn, State	"/	
	spit hours inera. y fille	a	29a. Certifier	1 Certifying Pl	nysician: To the best	of my kno	wledge, dea	th occurre	ed at the t	ime, date ar	nd place,	and due to the	e cause(s	) and manner as	s stated.
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	(Check only one)	2∐ Medical Exam	niner: On the basis of and manner st		ation and/or i	nvestigati	on, in my	opinion, dea	ath occurr	ed at the time	, date and	d place, and due	to the cause(s)
	Some this	ME	29b. Signature and	I title of certifier	1 1		-	2	9c. Licens	se number			29d. Da	te signed (Montl	n, Day, Year)
			1/1	1/1/10	101					D00672	258		0c	tober 8,	2008
	1		30. Name and addi	ress of person who	completed cause of	death (Iter	n 23a) (Type	, Print)							

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

OCT

0 9 2008

Nicholas J. Farrell, M.D., 9707 Medical Center Drive, Suite 300, Rockville, Maryland 20850

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 629 CAPPENT 4c. County of Death 08 ILICHARD /Medical Name (If not institution, give street and number) Examiner DWNVIEW DRIVE Acciden If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Apr 3, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 1 MM 2 □ F Yrs. 037-24-9091 69 Rhode Island Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or Items 23a or 28a-1 show other traumatic event, the Michigal Examinar must be inclified at MD Garrett Accident 1 X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21520 USA 101 Townview Drive, Apt 14 death 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiane. Important: If Item 27 is marked other than "natural", or Iter eny injury or other traumatic event, the Medical Examinat 1 Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. white Specify: 3 ☐ Widowed 4 🙀 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Laborer Labor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Alice Ray Marsh Chester Hiram Carpenter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 02911-1511 Geraldine J. Arvanites/sister 12 Brookside Ave., North Providence, RI 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Oct 18, 2008 Davidsville, PA 4 □ Donation 5 □ Other (Specify) Country Side Crem. 21. Signature of Funeral Service Lice Newman Funeral Homes, P.A., P.O. Box 275 179 Miller St., Grantsville, MD 21536 23a. Part1. Enter the disease, or opmplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear dilure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ANTEV 1090 aV disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine been signed by the attending physicien and should be deteched for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy 4☐Pregnant at time of death 5 ☐ Other (specify) page 2 should be deteched 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed 1∏ Yes 20 No 1 ☐ Yes 2 ☐ No I or Attending Physician: after death. Director: After this certifica filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home, 5 Residence 6 Other (Specify) 1 Inpatient 1 Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Injury at Work? Natural 5 Pending investigation njury 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital within 24 hours a To the Funeral Completely filled Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Additional Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month

DHMH 17 Rev 1/2001

32. Registrar's Signature

Description   The State   Th			State of Maryland / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Departme		•	ene	00011				
Charles Lewis Crumbie  An Factor Para Control State of St			_ State	rtificate of Death	Reg	, No. 2008	33814				
Continued   Cont	Physicia	ian				Day Year					
3100 Black Rock Road    September   Property			T	Oct. 5		5:40a <sup>™</sup>					
Control Security Number   100	Examin	er			พาก		~e				
215-32-0239 192 20 19 19 20 19 19 19 19 19 19 19 19 19 19 19 19 19							lace (State or Foreign				
Section   Sect			215-32-0239 1\(\overline{A}\mathbb{M}\\^2\mathbb{G}\mathbb{F}\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\		· mu	rear) Court	try)				
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30. Name and address of person who completed cause of death (Item 33a) (Type, Print)  My Lycal Schuctz 6535 Vortschwlesst, Suite 530 Powson, Mb  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature	y the attending physiclan a iched for use as the burial-	sician/Medical	d.  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No  d.  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 4 □ Pregnant at time of death 5 1								
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State 31. Date filed (Month, Day, Year) 32. Registrar's Signature  Registrar 0CT 0 8 2008 Alexander M. Angel.	775		30. Name and address of person who completed cause of death (Ifem 33a) (Type	Print)  Note Charles	St. Suit	0550 PW	Sch, 40				
				Shoull &			,				

			1 - For State of Maryland / Dep	artment of Health and Nartificate of Death	Nental Hygier Reg.:		
П	Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	3. Time of Death	
	/Media		PAULINE DILL COHEY		10 1	4 2008 5:00 P <sup>M</sup>	
	Examir	er	4a. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
	Euroval		CORSICA HILLS  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	CENTREVILLE  If Under 1 Year If Under 24 Hrs.	8. Date of Birth	UEEN ANNES  9. Birthplace (State or Foreign)	
	Funeral Director		215-20-4752 1□M 2\\ F\ 92 Yrs.	Months Days Hours Min.	n. (Month, Day, Year) Country)		
	P		Usual Residence of Decedent		05/28/191		
	arylar how	Ļ	10a. State 10b. County 10c. City, Town or L			10d. Inside City Limits	
	86-1-98	Scto	MD QUEEN ANNE'S CHESTER			Y Yes 2 □ No	
	with t	<u>a</u>	100. Street and Number	10f. Zip Code	10g.	Citizen of What Country?	
	ns 23	eral	100 RIVER ROAD           11. Marital Status         12. Was Decedent Ever in U.S.         13.	21620 Was Decedent of Hispanic Origin? (Sp	pacify Yas or No.	USA 14. Race - American Indian,	
5-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "naturel", or items 23a or 28e-f ehow thit, the Medical Examinar must be notified at	by Funeral Director	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, etc.  Specify: WHITE	
Ž	"natur	Completed	15. Decedent's Education 16a. Dec	edent's Usual Occupation	16b.	. Kind of Business/Industry	
Ž	thin 7	pie	(Specify only highest grade completed) (Giv Elementary/Secondary (0·12) College (1·4or 5+)	e kind of work done during most of work DO NOT use retired)	ang		
7	ed wil	Con	10 BOOH	KEEPER		LVAGE YARD	
Ē	B E S	Be	17. Father's Name (First, Middle, Last)	18. Mother's Nam	e (First, Middle, Maio	len Sumame)	
$\frac{3}{2}$	should by and Menta marked umaric ev	T <sub>0</sub>	WILLIAM DILL		A LISTER		
Maryland	2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2			ing Address (Street and Number or Ru		y or Town, State, Zip Code)	
17	1 and Health em 27 ther t		SHIRLEY DIXON PO  20a. Method of Disposition 20b. Place of Disp	BOX 126 HARTLEY,	DE 19953 Date 20c.	Location - City or Town, State	
و	Pages nent of l int: If its iry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	ematory or other place)		•	
Baitimore,	permit. Pages Depertment of I Importent: If It any injury or or once.	i	OHEST I			HESTERTOWN, MD	
ñ	Deg and page		August Illand	30 SPEER ROAD TE HESTERTOWN, MARYLA	ND 21620	ENBEIN & NEWNAM FH	
			23a. Part. Enter the disease, or complications that caused the death. Do not en chock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between	
	Physician		Immediate Cause /Final	and romeropathy		Onset and Death	
	/Medical		resulting in death)  Due to (or as a consequence of):	n disease		Jean	
	Examiner		Sequentially list conditions, b. Coronary puter	y disease		gens	
_	ed sit	iner	if any, leading to immediate cause. Enter Underlying			1100	
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C. BOX	that the death certificated by the attending postering for use as	Physician/Me		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year	
Ž.	that ined by detail	y Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	to use contribute to the cause of death?	
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ě L	The la ate has page 2	Completed			24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death? No 1 Yes 2 No	
	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?  Hospital: Hospital:		th Check only one		
5	d is X	₽:	1 Yes 2 No Poshial 1 Inpatient 2 ER/Outpatie  27. Manner of Death 28a. Date of Injury 28b. Time			6 ☐Other (Specify)	
	ding h. After fune	t P	Natural 5 Pending (Month, Day Year) Injury	of 28c. Injury at Work?  M 1 ☐ Yes 2 ☐ No	28d. Describe how in	njury occurred	
VISION	Attending in death.	ertification:	3 Suicide 6 Could not be		28f. Location (Street	and Number or Rural Route Number.	
5	s afte	Cert	4 ☐ Homicide determined building, etc. (Specify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	City or Town, St.	ate)	
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edlcai	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, deal and manner stated.	th occurred at the time, date and place, evestigation, in my opinion, death occur	and due to the cause red at the time, date a	o(s) and manner as stated. and place, and due to the cause(s)	
	Withir Comp	Me	29b. Signature and title of certifier	29c. License number	29d. I	Date signed (Month, Day, Year)	
	1.		· Pent	1775933		10.14.08	
	60		30. Name and address of person who complete cause of death (Item 23a) (Type	, Print)		11 21/10	
ħ.	ms co		31. Date filed (Month, Day, Year) 32. Registrar's Signature	amons Lane, E	1510n, p	(1) 6/601	
	Sta Registr		OCT 1 5 2008	Print) Chemans Lane, E			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October 2008 **Physician** 12 2050 JAMES D. CANNON SR. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Easton Talbot The Memorial Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 17€ M 2 □ F Director 62 215-44-6167 09/16/1946 MARYLAND Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 TYYes 2 No Director TALBOT TRAPPE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5828 OLD TRAPPE ROAD 21673 USA Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Y Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: WHITE ò 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Secondary (0-12) College (1-4or 5+) HEAVY EOUIPMENT OPERATOR uepartment of Health and Mental Hyo important: If Item 27 Is marker any Injury or other and Injury or othe 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ROBERT CANNON NOLA WILLS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5828 OLD TRAPPE ROAD TRAPPE, MD 21673 MARY J. CANNON/WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) SUDLERSVILLE 10/17/2008 SUDLERSVILLE 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 370 W. CYPRESS MILLINGTON, MD seritel Approximate Interval Between Onset and Death 23a Sant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Cavalio VAIWAN **Physician** SL/MOne 77/two SKWM/ /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed and Due to (or as a consequence of): burial-1 Box 68760 attending physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy for Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown þ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ģ 2 No 3 Probably 4 □Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of eause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has page 25. Was case referred to medical examiner? 2 No certificate 1∐ Yes Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 After this funeral 27. Manna f Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: or Attending 5 ☐ Pending investigation (Month, Day Year) 1 Natural Injury 1 Yes 2 No death. 2 Accident the f within 24 hours after death To the Funeral Director: 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner-stated. (Check only one)

State Registrar LUDIOIG 31. Date filed (Month, Day, Year)

5

29b. Signature and title of certifier

unde

SEDER

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registr

DHMH 17 Rev 1/2001

29c. License number

29d. Date signed (Month, Day, Year)

CYNLUSOD DR. EASTON MD 21601

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** OCT. 5, 09:00P M 2008 RALPH SAMUEL COX /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner KENT CHESTERTOWN 82 CLIPPER WAY Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 6. Sex 7 Age (In vrs. last birthday 5. Social Security Number Min. Months Davs Hours 1 XM 2 □ F 90 5/8/1918 MD 213-14-6414 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 1 ☐ Yes 2 No Director CHESTERTOWN KENT 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 82 CLIPPER WAY 21620 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2【No 11. Marital Status 1 ☐ Never Married 2 X Married If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: WHITE þ 3 Widowed 4 Divorced Completed 16b Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) AUTOMOTIVE MECHANIC 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MARIAN JOINER SAMUEL JOSEPH COX ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 82 CLIPPER WAY CHESTERTOWN, MD 21620 EDNA R. COX/WIFE 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State CHESTER CEMETERY 10/9/08 CHESTERTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility
LLOWS, HELFENBEIN
SPEER RD, CHEST 21. Signature of Funeral Service Licer NBEIN & NEWNAM FUNERAL HOME CHESTERTOWN, MD 21620 Kup Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) Physician/Medical IF FEMALE: 23d. Date of delivery 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 2 No 3 Probably 4 Unknown 1 □ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 \( \subseteq \text{ Nursing Home} \) Hospital: 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Certification: To 2 Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28h Time of 28c. Injury at Work? 5 Pending investigation 1 ☐Yes 2 ☐No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

law requires that the death certificate be executed and Box 68760. Ö ۵. of Vital Records, Division

the burialphysician use as Po page director funeral

4 ☐ Homicide

(Check only one)

29a. Certifier

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examilier must be notified at 900e.

**Physician** /Medical

Examiner

Saltimore, Maryland 21215-0036

been signed by the should be detached has e 2 certificate To the Hospital or Attending Physician: After this within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

State Registrar

Medical

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. License number 29b. Signature and title of certifie

29d. Date signed (Month, Day, Year)

of person who complete ath (Item 23a) (Type, Print) 30. Name and address

31. Date filed (Month OCT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year 09:01 AM **Physician** Dac October 2008 Edith /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner The Johns Hopkins Hospital **Baltimore City** BALTIMORE 8. Date of Birth (Month, Day, Year) 11/14/1919 If Under 1 Year If Under 24 Hrs Months Days Hours Min. ace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** PENNSYLVANIA 1 M 2 X 88 212-14-3190 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 2 should be filed within 72 hours after death with the Marylan and Mental Hygiene.
Is marked other than "natural", or Items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at 1 √ Yes 2 □ No Director PRINCE GEORGE'S LARGO MD 10g. Citizen of What Country? 10f, Zip-Code 10e. Street and Number 500 NORTH HARRY S. TRUMAN DR. # 422 20774 USA Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐
If Yes, Give
Year or Dates 2 🛛 No 1 Never Married 2 Married Specity: BLACK Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. ۾ 3 X Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12TH GOVERNMENT LPN 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pepartnent of Health and Mental i Important if them 27 Is marked on any injury or other traumatic pure. Be F. SMITH ISABELLE BRANCH ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) FAIELAKE PLACE MITCHELLVILLE, MARYLAND 20721 FRANCIS C. DADE/SON 1204 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State MD NATIONAL CEMETERY 10-20-2008 LAUREL, MARYLAND 5 Other 4 Donation becify) 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME of Funeral Servi Signatur 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between 23a. Part 1. Enter the disease, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** blood /Medical Due to (or as a consequence of) **Examiner** Ischemi( Sequentially list conditions, it is cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to or as a conse juence of The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 - Ectopic pregnancy Month Year in the past 12 months?
1 Yes 2 No 4 Pregnant at time of death 5 Other (specify) d by the at detached t 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. certificate has been signed lirector, page 2 should be de 2 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 TYes 2 XNo Yes or Attending Physician: 25. Was case referred to medical examiner? funeral director. 26. Place of Death Check onl on Be Other: 2 No 1 Inpatient 4 
Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Tes 2 ER/Outpatient 3 DOA ၉ 28a. Date of Injury After this 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: 1 Natural
2 Accident 5 Pending investigation Injury M 1 Tes 2 No 24 hours after death. Funeral Director: A completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide

Hospital

within 2 To the

State Registrar

Medical

Laukshmi 31. Date filed (Month, Day, Year) OCT 0 9 2008

29b. Signature and title of certifier

(check only

Lastime 32. Registrar's Sign

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

RES-OOC

29d. Date signed (Month, Day, Year)

10/07/2008

600 North Wolfe St, Baltimore, MD, 21287

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** 6:52 A<sup>M</sup> REE DIXON LILLIE October 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK 8. Date of Birth (Month, Day, Year) Oct. 13,1928 If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. | 9. Birthplace (State or Foreign Country) South Carolina 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days 1 □ M 2 🂢 F 79 250-38-9050 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f show ?7 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Medical Examinar must be nothed at 1 Yes 2 No Director MD Frederick Frederick 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number e filed within 72 hours after death with tall Hygiene.
other than "natural", or items 23a or? 21703 USA Funeral 577 Primus Court 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black Completed by 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Seamstress 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental Tom Henry is marked Ida Fullwood 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 577 Primus Court, Frederick, MD 21703 19a. Informant's Name/Relationship (Type. Print) Brenda Morris / Niece permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other trat once. 20b. Place of Disposition (Name of Femetery, crematory or other place)
ROOSEVELT
Memorial Park 20c. Location - City or Town, State 20a. Method of Disposition 1 Ŋ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake, 10/11/08 22. Name and Address of Facility Greene Funeral Home 21. Signature of Funeral Service Licensee Mesne Shu 814 Franklin Street, Alexandria, VA 22314 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) STAGE **Physician** /Medical Due to (or as a consequence of): CORONARY METERY DISEASE Examiner ATHENU SCLENOSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year 5 ☐ Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 9 Unknowf 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1)XYes 2 □ No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 □ Yes 2 2 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 21 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Duath 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Hospital or Attending 1 Natural 2 Accident 5 Pending investigation nours after death. neral Director: Aft y filled in by the fun 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours a To the Funeral D TECERTIFYING Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 47951 10-07-2008 JWW 7 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TOLL HOUSE AVE . + PREDERICE Mn 21701 SIBTE A. KAZMI, M.17 814 Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death October 9, 2008 Year Physician de Castro В. 10:00 A Ligaya /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2703 Chris Court Ft. Washington Prince George's If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Months Days 1 □ M 2 🖺 F Philippines 218-19-5616 July 23, 1946 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2√√No Maryland Prince George's Ft. Washington Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20744 2703 Chris Court Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2xxNo 1 Never Married 2XXMarried 1 ☐ Yes 2 🖾 No If Yes, Give Specify: Filipino ò 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Admitting Officer Ft. Washington Hospital 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Christy Santos Bravo Sr. Alejandro ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2703 Chris Court Ft. Washington, Maryland Edgardo S. de Castro / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 10/14/2008 Clinton, Maryland Resurrection Cemetery 4 Donation 5 Dother (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home PA 21. Signature of Funeral Service Licensee 6160 Oxon Hill Road Oxon Hill, Maryland 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions ir any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a someoquenes of). Exam Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) I∐Yes 2**XX**No 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4XX Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 2 No

**Physician** /Medical Examiner

permit. Pages 1 Department of H Important: If ite any Injury or ot once.

**Funeral** 

Director

ral", or items 23a or 28a-f sh Examinationst be multiped

Pages 1 and 2 should be filed within 72 hours after death with innent of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or items 23a or:

event, the Medical

Baltimore, Maryland 21215-0036

physician and s the burial-trans attending pl been signed by the should be detached certificate has be irector, page 2 sl funeral n 24 hours after death.

e Funeral Director: A pletely filled in by the fu

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Completed Be Certification: To

1 ☐ Yes 2XX No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 50 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural 1 ∐Yes 2 ∐No 2 Accident 6 ☐ Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

143276

Imelda Miranda MD nd address of person who completed cause of death (Irem 23a) (Type, Print)

State Registrar

Medical

31. Date filed (Month, Day, Year)



within 2

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death Month Day October 2, 2008 Medical Examiner 0621 hrs Robert Fred Detrick 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 256 Paul Fisher Road Friendsville Garrett 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or **Funeral** Months Days Director Hours 219-46-0675 July 3, 1945 63 Yrs 1 X M 2 Country) Maryland Usual Residence of Decedent 10a, State ì 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show MD Garrett Friendsville 1 Yes 2 X No notified at once, with the Maryland Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or 1080 Friendsville-Addison Rd. 21531 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-14. Race - American Indian, Black, must be hours after death If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White, etc Never Married 2 X Married 1 X Yes No Ģ Widowed If Yes, Give Year Vietnam Divorced the Medical Examiner Yes 2 X No specify: Specify: White 2 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 6b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Pages 1 and 2 should be filed within 72 bent of Health and Mental Hygiene.
ant: If item 27 is marked other than " College (1-4 or 5+) 21215-0036 Lumber Company Loader 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be or other traumatic event, Demetrious Detrick Sadie Sines 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21531 Baltimore, MD 1080 Friendsville-Addison Rd., Friendsville, MD Paula Detrick/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation Removal from State Important: 1 Oct. 5, 2008 Sand Spring Cemetery Friendsville, MD Donation 5 Other Specify 21. Signature of Juneral Service Licensee 22. Name and Address of Facility Newman Funeral Homes, P.A. eumale P.O. Box 275, Grantsville, MD 23a. Part I. Epter the diseasel or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause on each line. Between Onset and /Medical a. Atherosclerotic Cardiovascular Disease Death Immediate Cause (Final disease xamine or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death certificate be executed Physician/Medical UNPENDED cate has been signed by the attending physician page 2 should be detached for use as the burial AMENDED Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Year Day past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Linknown Part II. Other significant conditions Division of Vital Records, P.O. contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ Yes 2 No 3 Probably 4 ✔ Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of this certificate has performed? death? ✓ Yes 2 No ✓ Yes 2 Nο To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Other; 2 DOA Inpatient ER/Outpatient 3 Residence 6 V Other: Scene Nursing Home 5 1 🗸 Yes No After 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 V Natural within 24 hours after death To the Funeral Director: completely filled in by the Pending Yes 2 No 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide determined Homicide 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 2 🗸 and manner stated 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) , m O.C.M.E October 3, 2008 30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) Registrar's Signature State

Registra

08-07562	
Bobby Ennels	

by Ennels	1	State of Maryland /	Department of Certificate of	Health and Mental I Death	nyglerie Reg. No	2008 3382	
Physicia	an/	Decedent's Name (First, Middle,Last)			2. Date of Death Month Day October 7, 200	3. Time of Death	
edical Examiner		Bobby J. Ennels  4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location				oc. County of Death	
		Prince George's Hospital Center		Cheverly		Prince George's	
Funeral Director		6. Sex 7. Agr 7.	e (In yrs. last birthday) 2 Yrs		Hrs. 8. Date of Birth (MN) 100 5 / 12 / 198	MDD/YYYY) 9. Birthplace (State or Foreign Country)Maryland	
death with the Maryland or items 23a or 28a-f show any must be notified at once.	-	Jsual Residence of Decedent  10a, State 10b, County	10c. City. Town or Locat	ion		10d. Inside City Limits	
		MD Prince George's	Capitol He	ights		1 XYes 2 No	
	횽	10e. Street and Number		10f. Zip Code	10g. C	itizen of What Country?	
	ä	7601 Millrace Road		20743		ited States	
h with ems 23	Funeral Director	11. Marital Status  1 X Never Married  1 Married  1 Armed Forces		as Decedent of Hispanic Origin? Yes, specify Cuban, Mexican, Pu	( Specify Yes or No- erto Rican, etc.)	14. Race - American Indian, Black, White, etc.	
er deati , or ite	ᇤ	Yes 2	X No	Yes 2 No specify:		Specify: Black	
urs afte tural" amine	a A	Widowed     W	moleted) 16a Decede	nt's Usual Occupation (Give kind nost of working life. DO NOT use		. Kind of Business/Industry	
5 72 hoi in "na cal Ex	ete	Elementary/Secondary (0-12) College (1-4 or	5+)	verv Driver		auto store	
Baltimore, MD 21215-0036  Department of Health and Mental Hegd within 72 hours after death with the Maryland Department of Health and Mental Hygeine Important: If tiem 77 is marked other than "natural", or items 23a or 28a-f she nijury or other traumatic event, the Medical Examiner must be notified at once	Completed	12 17. Father's Name (First, Middle, Last)		•	ame (First, Middle, Maide	en Surname)	
	Be C	Bobbie Bell					
	다 I	19a. Informant's Name/Relationship (Type, Print )		ng Address (Street and Number			
and 2 shou fealth and N tem 27 is n traumatic		Bobbie Ennels (Mother) 20a. Method of Disposition	7601	Millrace Rd. Cosition (Name of cemetery,	Capitol Hei	ic. Location - City or Town, State	
Baltimore, Mpermit. Pages I and 2 Department of Health Important: If item 2 injury or other trau		1 X Burial 2 Cremation 3 Removal from S		other place) coln Cemetery 1	.0/15/2008 F	Brentwood, MD	
	1 3	4 Donation 5 Other S ecify: 21. Signature of Funeral S violaticensee	-1	Name and Address of Facility			
		f ff the	3.4	01 Bladenshuro	Road Brent	twood, MD 20722	
Physician		Approx.  23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
/Wedical caminer		Immediate Cause (Final disease a. Gunshot Wour		Death			
	8.3	or condition resulting in death)  Due to (or as a consequence of):  b.					
	ne.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):					
	Examiner						
<b>0,</b> be executed sician and burial - transit	m	d.					
	edical	UNPENDED				23d. Date of delivery	
Box 6876C he death certificate the attending physhed for use as the b		IF FEMALE: 23c. If yes, outcomes 23b. Was decedent pregnant in the 1 Live birth	Fetal death 3 Ectopic p		Month Day Year		
Box 6876  e death certificate the attending phy ed for use as the	icia	past 12 months?  4 Pregnant  1 Yes 2 No 9 Unknown g Linknown	Other (Specify)				
, P.O. Bo res that the dea signed by the a be detached fo	Physician/M	Part II. Other significant conditions contributing to de	e underlying cause given in Part		cco use contribute to the cause of death?		
	3				1 Yes	2 No 3 Probably 4 Unknown	
ords, w require	Completed by				24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of	
sion of Vital Recontending Physician: The ladeath. ctor: After this certificate he yet fineral director, page 2	I du				performe 1 <b>V</b> Yes 2		
	ပို	25. Was case referred to medical		26.Place of Death (C			
	To Be	1 Yes 2 No	atient 2 ER/Outpatie	511. 0 511	Nursing Home 5 Re	esidence 6 Other:	
		27. Manner of Death 28a. Date of (Month Da Oct 7, 2008)	njury 28b. Time ( y,Year) 0028 hrs	1 Yes 2 V	Subject shot	<b>,</b>	
	cati	2 Accident Investigation 28e. Place o	f Injury - At home, farm, s	treet, factory, office building, etc.	28f. Location (Str.	eet and Number or Rural Route Number, City	
Divi	Certification:	3 Suicide 6 Could not be	(Specify) Local Street			or Town, State) 406 Nalley Road and Twining Court, Landover, MD	
Divis  To the Hospital or A within 24 hours after To the Funeral Dire completely filled in the		29a Certifier and due to the cause(s) and manner as stated.					
	Medical	one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and manner stated.  29d Date signed (Month, Day Year)					
	Ž	29b. Signature and title of certifier		O.C.M.E.		October 7, 2008	
Q		30. Name and address of person who completed cause	of death (Item 23a)				
0	7	Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201					
	Stat	31. Date filed (Month, Day, Year) 32. Regis	strar's Signature	te)			
	istra	- 27311W #44	, J.S. A.J.				

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Figure 10/9/08, BW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 1: 40 A M 10 KYUNG ETTEN 07 2008 SOON VAN /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner COUNTY HOWARD GENERAL HOSPITAL COLVMBIA - MD If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 ☐ M 2 🕱 F Director 219-54-8703 80 Jan. 11, 1928 Korea Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits show 10b. County a or 28a-f show t be notified at 1 ☐ Yes 2 ☑ No Director Prince George's Maryland Beltsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4517 Yates Road 20705 USA ral", or items 23a Examiner must b Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2√√No Specify: Asian þ 3 Widowed 4 □ Divorced Year or Dates: 'natural", 12 should be filed within 72 hou th and Mental Hygiene. 7 is marked other than "natura traumatic event, the Medical E. Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental i Important: If item 27 is marked on any injury or other traumation Be Chi Wang Whang Dai Yul Tak ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anita F. Thompson/Daughter 4517 Yates Road, Beltsville, MD 20705 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Oct Metropolitan Crematory 4 □ Donation 5 □ Other (Specify) 2008 Alexandria, Virginia 21. Signature of Funeral Service Licensee francis Addess Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** RESPIRATORY FAILURE /Medical Due to (or as a consequence of): Examiner ULMONARY (SUB MASSIVE) EMBOLISM Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760, attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. ed by the a 9 Unknown signed be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown HYPERTENSION; DIABETES MELLITUS: Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an page 2 s autopsy performed2 2 No 2 No ispital or Attending Physician: Thours after death.

neral Director; After this certificate y filled in by the funeral director, pa 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital: 1 ☐ Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA P 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C Hospital 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State

Registrar

0

31. Date filed (Month, Day, Year)
OCT 0 9

AMADO

LUCIANO

5755 CEDAR LANE
32 pegistrar's Signature
2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DAR LANE, COLUMBIA MD
ar's Signature

D6712

Oct 07, 2008

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Deto ber Year **Physician** 1855 PM Timothee Ekani , 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Months Days Hours Min. AUG 12, **Director** 219-02-1028 66 1942 Cameroon Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a ~ "0-" any injury or other traumatic event. Its marked once. 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 □Yes 2 No Director MDNorth Potomac Montgomery 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code 20878 14644 Devereaux Terrace Cameroon Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 ∑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 XNo \$ Specify: 3 Widowed 4 Divorced **Black** Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Embassy of Elementary/Secondary (0-12) College (1-4or 5+) Foreign Attache Cameroon 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) æ Ekani Blandine Richard ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12904 Falling Water Cir.#101, Germantown, MD 20874 <u> Joseph Ekani / Son</u> 20b. Place of Disposition (Name of cemetery, crematory or other place)
LifeLegacy 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 🖾 Removal from State 4 Donation 5 ☐ Other (Specify) 10/08/2008 Tucson, AZ Foundation 21. Signature of Fungral Service Licenses 22. Name and Address of Facility Thibadeau Mortuary Service, P.A. M00956 933 Gist Avenue, LL, Silver Spring, MD 20910 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** MINUTES CARDIOPULMONARY ARREST disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner HEPATIC FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Exami CIRRHOSIS OF THE LIVER Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 ☐ Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ⋧ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24a. Was an autopsy performed? 1 □ Yes 2 Å No 24b. Were autopsy findings available prior to completion of cause of death? 1∐Yes 2⊠No funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 **X**No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 X Natural 24 hours after death. 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 Sulcide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 Ches D0065505 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 Medical Center Dr. Rockville. CHENG FANG M.D 31. Date filed (Month, Day, 32 Registrar's Signature State 0 9 OCT 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 33825 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** B. October 5. Edmonia Foster 2:00 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Ft. Washington Ft. Washington Health & Rehab. Center Prince George's 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) October 5, 1920 9. Birthplace (State or Foreign Country) Virginia 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 136-26-9602 1 □ M 2K F 88 **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mertial Hygiene.
ant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show ant: If Item 27 is marked other than "natural", or other traumatic event, he Medical Event increment and the notified at very or other traumatic event, he Medical Event increments. 10a. State 10c. City, Town or Location 10d. Inside City Limits N/A N/A Washington D.C. 1 X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 4619 Hilltop Terrace S.E. 20019 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 **Black** 1 ☐ Yes 2 🗓 No Specify چ ک 3XXWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) D.C. Public Schools School Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Tunstall William 1 Morgan Banks Bertha ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Priscilla Yarborough / Daughter 3525 25th Place Temple Hills, Maryland 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date permit. Pages Department of Important: If it any injury or or 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 10/11/2008 Union Cemetery Chatham, Virginia 5 ☐ Other (Specify) 4 Donation 21. Signature of Funeral Service Licenses 22. Name and Address of Facility George P. Kalas Funeral Home P.A. 6160 Oxon Hill Road Oxon Hill, Maryland 20745 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** /Medical Examiner Division of Vital Records, P.O. Box 68760,

physician and s the burial-trans s been signed by the should be detached cate has l

or Attending Physician: The law requires that the death certificate be executed ours after death.

neral Director: After this certific filled in by the funeral director,

29b. Signature and title of certific

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

	disease or condition resulting in death)	a. Dollar	16				
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Examiner	Sequentially list conditions, if any, leading to immediate the conditions of the con	b					
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hysician/Medical	IF FEMALE; 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 XXNo 9 □ Unknown	23c. If yes, outcome of pregn 1  Live birth 2 Fete 4 Pregnant at time of 9 Unknown	al death 3 Ectopic			23d. Date of delive	ery Day Year
о.	Part II. Other significant conditions of	ontributing to death but not res	sulting in the underlying	cause given in Part I.	23e. Did tobacco	use contribute to th	ne cause of death?
Completed by					24a. Was an autopsy performed? 1 □ Yes 2 🖾 N	prior to con death?	psy findings available mpletion of cause of 2 □No
Be	25. Was case referred to medical examiner?			26. Place of De	ath (Check only one)		
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ertification:	27. Manner of Death 1XXXNatural 5 ☐ Pending 2 ☐ Accident investigation		28b. Time of Injury M	28c. Injury at Work? 1 □Yes 2 □No	28d. Describe how inju	ury occurred	
Sertific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, street, factory)	ory, office	28f. Location (Street a City or Town, Sta	and Number or Rura te)	d Route Number,
dical (		nysician: To the best of my known in the basis of examination and manner stated.					

29c. License number

202256

29d. Date signed (Month, Day, Year)

Rond Fut Washington moryland 20744

State Registrar Civingin

11701

08-07376 Yvette Fisher Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2008 33826

		- For State	(	Certificate c	of Death	7				Reg. No.			
Physicia		te <del>distrai</del> 1. Decedent's Name (First, Middle,Last	)					2.	Date of De	eath			ne of Death
ledical Examin		YVETTE	YVETTE FISHER  Month Day Year September 28, 2008  a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death										13 hrs
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<b>-</b>	٩.	5. Social Security Number 6. Se	x 7. Age (In	rs. last birthday)	If Unde	r 1 Year	If Under	24Hrs.	8. Date of I	Birth (MM/	DD/YYYY)	9. Birthplace	(State or
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Baltimore, MD 2 permit. Pages I and 2 shou Department of Health and I Important: If item 27 is n injury or other traumatic		21. Signature of Funeral Service Licer	isee	22	. Name and	Address	of Facility	J.	B. J.	ENKI	NS FUN	NERAL	HOME
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Physician		23a. Part I. Enter the disease, or comp	olications that caused the	death. Do not ente	r the mode	of dying, s	such as ca	ardiac or i	respiratory	arrest, sh	ock, or hea	rt Ap	proximate Interval tween Onset and
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transitions.	Medical		er:On the basis of examina and manner stated.	uon and/or invest				-uned at	une unite, C				
	ž	29b. Signature and title of certifier			29		e number					ed (Month, L	
		his m	, mis			O.C.I	M.E.			Se	eptember	28, 2008	
2 2		30. Name and address of person who	completed cause of deat	n (Item 23a)							-		
R2		Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201											
	tate		32. Registrar's										
3	CH-	DCT 0 9 2008	Z. Z.	March 1									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene > ( Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** Veno A. Fuller 10/ /Medical 03/ 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 1408 Iverson St., Apt#101 Prince Georges Oxon Hill If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 4/29/1951 7. Age (In vrs. last hirthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 1 F Yrs. Director 577-70-4015 Wash. D.C. Usual Residence of Decedent worke 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ?? is marked other then "naturaf", or items 23s or 28s-f ehov treumatic event, the Madical Examinar must be notified at Director 1 ☐ Yes 2 No Prince Georges Oxon Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20745 U.S.A. Funeral 1408 Iverson St 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify ģ Specify: 3 Widowed 4 □ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Teacher Day Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be is marked of 8 John Edward McCall Mattie Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if item 27 is Rainell Fletcher/Daughter 1512 Iverson St., #101, Oxon Hill, MD 20745 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Depertment of Important: if eny injury or once. Harmony Mem 10-10-08 Largo, MD 4 ☐ Donation 5 ☐ Other (Specify) Nat'l 21. Signatur of Funeral Service Licenses 22. Name and Address of Facility Universal Morcuary Marle 411 Kennedy St., NW, Washington DC 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) lung Cancer years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the death certificate be executed ettending physicien and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FFMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 4 Pregnant at time of death 9 Unknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 XYes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

**Physician** 

Baltimore, Maryland 21215-0036

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Medical

Certification: Japital ... 4 hours efter dea... ... ... Air

page 5 certificete Attending Physician: director. this

To the Hospital o within 24 hours ef To the Funeral Di

1 Yes 2 No 26. Place of Death Check only one

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 □ Yes 2 □ No

2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

1 \_\_ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
 2 \_\_ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier Willes & Allower MD 29c. License number

29d. Date signed (Month, Day, Year) Detaker (0, 2008

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Clinton, MD 20735

1 Yes 2 No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nicholas A. DeMonaco

8926 Woodyard Road Swite 201

31. Date filed (Month, Day, Year) State 0 2008 Registrar

29a Certifier

32. Registrar's Signature

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar		Stat	e of Ma	arylan	d / Depa			lealth a Death	and M	ental Hy	/giene Reg. No.	2008	3382	8
	Physici		1. Decedent's Nan WALTER		e, Last) FAWCETT	Sr.							2. Date of D		2008 ear	3. Time of Death 10:45 A	
	/Medic Examir		4a. Facility Name <b>Wilson</b>	(If not institution Health							Location			4c.	County of Dea		
ī	Funeral Director		5. Social Security 578-52-		6. Sex 1 ፟፟ M 2 □	7. Age	e (In yrs. 67	last birthday) Yrs.		er 1 Year	If Under Hours		8. Date of B (Month, D July 2		_	thplace (State or Fore puntry) hington D.	-
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	/Medical Examiner		resulting in death	1	Di Di	ue to (or as a	a consequ	uence of):									
	ecuted and -transit	Examiner	Sequentially list or if an leading to in cause. Enter Und Cause (Disease of that initiated event resulting in death)	nditions, nmediate erlying r injury is Last	c	ue to (or as a											
<b>5876U</b> ,	lificate be executed g physician and as the burial-transit	edical E	,		d	Je to (or as a		uence ory.									_
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cords, P.	requires that the een signed by th nould be detache	ρ	Part II. Other sign	ificant condition	ons contributing	g to death bu	it not resu	ulting in the u	nderlying	cause give	en in Part I					o the cause of death?	₩n
15	: The law recate has bee	Completed											perf	s an opsy ormed? 2 <b>X</b> No	prior to death?	utopsy findings availab completion of cause o	ole of
VItal	sician certifi rector	Be	25. Was case refe examiner?		Hospital:					Othe			(Check only				
0	g Phy er this eral di	n: To	1 Yes 2 27. Manner of Dea	ith	28a.	Date of Injur	y	ER/Outpatier 28b. Time of		28c. Injur Work	4 LALINU		ne 5∐ Res 28d. Describe		Other (Sp.	ecify)	—
JIVISION	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 s	Certification:	1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	5 ☐ Pendin investig 6 ☐ Could i determ	gation not be 28e.	(Month, Day	ry - At ho	Injury ome, farm, str	M eet, facto	1 🗆 '	<br Yes 2□					ural Route Number,	
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Ÿ	the Hin 24 the Fu the Fu hin 24 the Fu hpletel	Medical	(Check only one)		and	the basis of manner sta	examina ted.	tion and/or in				ath occurr	ed at the time			e to the cause(s)	
	2 P P P P P P P P P P P P P P P P P P P	2	29b. Signature and	Jes	1			Dru		DO05	59423				ober 7,		
			30. Name and add	di Feir	nberg M	.D.	201	Russe1		e. Ga	aithe:	rsbur	g, MD	2087	7		
	Sta Registr		31. Date filed (Mo		2008	32 Registra	ır's Signa	ture	natt p	_							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.

amend 1tem 20b per fh 8885 11-5-08 vt

State of Maryland / Department of Health and Mental Hygiene 2 0 0 8

Amend Item 26, g884, 10/24/08dhb

Certificate of Death

Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician A.M October 11, 2008 2:27 au /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Garrett County Memorial Hospital Garrett 0akland If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Jan. 10, 1985 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1**)** M 2□ F Yrs. **Director** 219-15-5149 Maryland Usual Residence of Decedent with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 ☐ Yes 2 ☐ No MD Garrett Deer Park Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Івете 23a or 21550 United States 265 Deer Park Hotel Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 ☐ Married ō Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify à 3 Widowed 4 Divorced natural', White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 72 al Hygiene. the Me Elementary/Secondary (0-12) 12 College (1-4or 5+) Mechanic Auto Dealership rmit. Pages 1 and 2 should be filed w partment of Heelth and Mental Hygler portant: If teem 27 is marked other the Jinjury or other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Curtis Eugene Glotfelty Marv Victoria Friend 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 265 Deer Park Hotel Rd., Deer Park, MD 21550 Mary Victoria Glotfelty, Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any Injury or 4 □ Donation 5 □ Other (Specify) Garrett Memorial Gardens Oakland, MD David A. Burdock Funeral Home, P.A. 21 N. Second St., Oakland, MD 21550 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** mal MINGTES disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of) ettending physicien Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. 9 ☐ Unknown sete has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 3 No 2∏ No 1 ☐ Yes 1 Tyes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death Check only one examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 5 Other (Specify) Certification: To this After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred CNASHED VENICE, 28b. Time of multiple Division 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation 01:50 aM 10/11/ ROllOVER within 24 hours efter death To the Funeral Director: , completely filled in by the f 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 4153 Broadford oakland rek 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) Zimedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 006 (80 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Muczyrski ,311 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

OCT

2008

Registrar

NAMA KNOWN to Physican; Gollion, St Baltimore, Maryland 21215-0036 P.O. Box 68760,

For Amend Item 23a per dr., 8884, 10 24, 108din Health and Mental Hygiene Registrar 3383 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 3:15 PM Stuart Gordon Gullion, Jr. september 29 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ceci POINT PERRY VA MARYLAND HEALTH CARE SYSTEM If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 ☑ M 2 □ F Months Days Hours Min. 9/12/1948 West Virginia 60 Director 213-52-8297 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Mudical Examinar must be notfilled at Havre de Grace Director Harford MD 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 'natural", or items 23a or U.S.A. 21078 3734 Rock Run Rd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No Specify: ş Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than "any righty or other traumatic event, the Magnee. Elementary/Secondary (0-12) College (1-4or 5+) Heavy Fquip operator Laborer 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mae Irene Blevins Stuart G. Gullion, Sr. ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12 Tayroo de Grace, MD 21078 19a. Informant's Name/Relationship (Type. Print) Havre de Grace, MD 3734 Rock Run Rd. Maribelle B. Gullion (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 10/3/08 Aberdeen, Maryland Harford Mem. Gdns. 4 □ Donation 9 □ Other (Specify) 22. Name and Address of Facility
Tarring-Cargo Funeral Home, P.A.
Aberdeen, Maryland 21001-3399 21. Signatul es 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Due to (or s a consequence of): UNKNOWN disease or condition resulting in death) /Medical Examiner Chronic Obstructive Pulmonary Disease Sequentially list conditions, if any, leading to mineriate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 C Ectopic pregnancy Year Month Day 5 ☐ Other (specify) signed by the a ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an cate has page 2 s autopsy certificate 2 No 1 TYes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation 1 Natural ours after death.

neral Director: Af
filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) September 29, 2008 D27578 511 30. Name and address of person who completed cause of death (Item 20) (Type, Print) Aveli H.D. VA MAN 32. Registrar's Signature Hernandez VA MARY LAND HEALTH CAME SYSTEM DERRY POINT, HO 21902 31. Date filed (Month, Day, Year) State 3 Registrar 2 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. P.O. Box 68760. Division of Vital Records, After this certificate

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completely filled in by the funeral director, page 2 should be detached for use as the burial-trans	Medical Certification: To Be Completed by Physician/Medical Exam
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**Physician** 

/Medical

**Examiner** 

Director

Funeral

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Completed

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**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, In Mindical Examiner Property ones.

**Physician** 

/Medical

that initiated events resulting in death) Last	Due to (or as a consequence of):			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown		opic pregnancy ner (specify)		23d. Date of delivery Month Day Year
Part II. Other significant conditions of	contributing to death but not resulting in the underl	ying cause given in Part I.		co use contribute to the cause of death?  2 No 3 Probably 4 Unknown
			24a. Was an autopsy performed 1 □ Yes 2 🛣	24b. Were autopsy findings available prior to completion of cause of death?  No 1 □ Yes 2 ☒ No
25. Was case referred to medical examiner?		26. Place of Dea	th (Check only one)	
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3	☐ DOA Other: 4 ☐ Nursing H	ome 5X Residence	6 Other (Specify)
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigatio	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury	28c. Injury at Work?  ✓ 1 □ Yes 2 □ No	28d. Describe how in	
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		factory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, late)
29a. Certifier (Check only one)  1 ★ Certifying Pl 2 ★ Medical Example 1	nysician: To the best of my knowledge, death oc miner: On the basis of examination and/or investi and manner stated.	curred at the time, date and place gation, in my opinion, death occu	e, and due to the caus erred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
29b. Signature and title of certifier		29c. License number	29d.	Date signed (Month, Day, Year)
1 Jan to a	Ju ~- ?	10206 DC		Oct. 6, 2008
30. Name and address of person who James L. Davis,	completed cause of death (Item 23a) (Type, Print M.D. 6939 Georgia Av		)3 Washing	gton, DC 20012
31. Date filed (Month, Day, Year)	32. Registrar's Signature			
OOT 0 0 2008	Le be March			

Registra

State

		Ple	ase Type or State				delible Ink. artment of H			/	gible 8	338	333
		for State Registrar	Olalo	or war	ylalla /		tificate of L			Reg. No.			
Physici /Medio		1. Decedent's Name (First, Mid Richard Staple		iens					2. Date of Dea Month Oct. 6	Day	Year	3. Time of 2:20	Death P M
Examin		4a. Facility Name (If not institut	on, give street and n	umber)			4b. City, Town, or	Location of Death	1		nty of Death		
		4619 Harvard I	Road				College					orge's	
Funeral Director		5. Social Security Number 216–22–0208	6. Sex 1 ☑ M 2 ☐ F	7. Age (	In yrs. last bi	rthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day Oct. 1	, Ye <i>ar)</i> 1 <b>,1</b> 919	I Cou	place (State o ntry) Sa,Virg	
A		Usual Residence of Decedent  10a. State 10b. Coun		1	0c. City, Tow	n or Lo	cation					10d. Inside Cit	ty Limits
Sa-f sho tified at	ctor		e George'		College							1X Yes	2 No
3a or 28 st be no	al Director	10e. Street and Number 4619 Harvard I	Road				10f. Zip Code 20740			10g. Citizen ( USA	of What Cou	ntry?	
ritems 2	Funeral	11. Marital Status 1 □ Never Married 2 □ Ma	12. Was De	cedent Ever Forces?	er in U.S.	1	Vas Decedent of Hi f Yes, specify Cubar	spanic Origin? (S n, Mexican, Puert	pecify Yes or No- o Rican, etc.)		Race - Ameri Black, White,		
al", o	þ	3 ☑ Widowed 4 ☐ Divorce	If Yes (			1	□Yes 2⊠No	Specify:		Spe	cify: Wh	ite	
perfill. Fages I and 2 should be filled within 7.2 hours after death with the Marylan perfill. Fages I and 2 should be filled with the Martal Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Iha Madical Examiner must be notified at once.	Completed	15. Decede (Specify only high Elementary/Secondary (0-12)	ent's Education lest grade completed	(1) (1-4or 5+)	168	(Give	lent's Usual Occupa kind of work done d OO NOT use retired,	luring most of wor	king	16b. Kind of	f Business/Ir	ndustry	
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I Men narke	은	Thomas E. Houd							A. Harlo				
th and 7 is m traum		19a. Informant's Name/Relation		1			g Address (Street &						
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rages ment of ant: If it ury or o		1 ⊠ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other		n State			sition (Name of natory or other place Cemetery	i		Louisa	•		
Depart Import any inj		21. Signature of Funeral Service		Roger	S		Name and Address	•	me, P.A.	4739 Hyatt	Balti svill	more Av	7enue 20781
		23a. Part 1. Enter the disease, shock, or heart failure. Li	or complications that st only one cause or	caused th	e death. Do	not ente	er the mode of dying	g, such as cardia	or respiratory ar	rest,	-	Approximate Interval Bet	ween
hysician		Immediate Cause (Final disease or condition	52964		1 Infa	arct	ion					Onset and D	
/Medical Examiner		resulting in death)			onsequence								
.xuoi	<b>a</b>	Sequentially list conditions,			ostruc		Lung Dia	sease			_	10 Year	îs
nsit	mine	r any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	<b>4</b>	o (or ao a e	onsequence	017.							
Due to (or as a consequence of):													
the attending physiciple of the forms of the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown		e birth 2[ egnant at tir	pregnancy □ Fetal deat me of death		Ectopic pregnancy Other (specify)	/		23d.	Date of deli		Year
n signed t	by	Part II. Other significant cond	tions contributing to	death but r	not resulting	in the ur	nderlying cause give	en în Part I.				the cause of dobably 4 🔲 l	
cate has been signed by the page 2 should be detached.	Completed								24a. Was autop perfor 1 \( \text{Yes} \)	rmed?	prior to codeath?	opsy findings ompletion of c	available ause of

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

within 24 hours after death.

To the Funeral Director: After this certificate completely filled in by the funeral director, pag

To the Hospital or Attending Physician; The

Medical Certification: To Be

State

28a. Date of Injury (Month, Day, Year)

29c. License number

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

D26287

1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 🛭 Residence 6 Other (Specify)

28d. Describe how injury occurred

10/08/2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

# 107, College Park, MD 20740 7305 Baltimore Michael J. Berard Ave.

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

Injury

5 Pending investigation

6 ☐ Could not be

determined

25. Was case referred to medical examiner?

29b. Signature and title of certifier

1 Yes 2 No

27. Manner of Death

1 🔀 Natural

2 Accident

3 Suicide

29a. Certifier (Check only one)

4 Homicide

Registrar

			1 - State Registrar		State of Mi	ai yiai ic		rtificate of		мена пу	Reg. No.	008	3383
ı	Physici /Medic		1. Decedent's Name	e (First, Middle, Las VERLON	•	HARV	EY-WH]	TE		2. Date of De Month OCT •	Day	Year 008	3. Time of Death 11:45 A <sup>M</sup>
200	Examir		4a. Facility Name (I		e street and number)				r Location of Deat			y of Death	1 -1 -1 -1 -1 -1 -1 -1 -1 -1 -1 -1 -1 -1
Jane !			PRINCE	GEORGE 'S	HOSPITAL			CHEV	ERLY		PRIN	ICE GE	ORGE'S
	Funeral Director		5. Social Security N 217-56-8	8429	ex 7. Ag	e (In yrs. la 57	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, D	rth	9. Birthp	lace (State or Foreign try) PAN
	pui		Usual Residence of 10a. State	Decedent 10b. County		100 City	Town or Lo	notion				14	0d. Inside City Limits
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	he M	Director	MD.	PRINCE G	EORGE'S		F	IVERDALE	PARK				1√ Yes 2 No
	with t	큡	10e. Street and Nur					10f. Zip Code			10g. Citizen of		•
	sath	eral		OGLETHOR		F	140.1	207			144.5	U.S.A	
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hyglene. I health and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Macical Extantor must be notified at	by Funeral	11. Marital Status 1 ☐ Never Marri 3 ☐ Widowed	ed 21 Married 3	12. Was Decedent Armed Forces? 1 ☑ Yes 2 ☐ I If Yes, Give Year or Dates:	No		Vas Decedent of N fYes, specify Cub 1 □Yes 2√√ No	an, Mexican, Puer  Specify:	to Rican, etc.)	Speci	ce - Americ ack, White, e fy: BLA	etc.
Õ	2 hot	Completed		15. Decedent's Ed	ucation	I	16a. Dece	dent's Usual Occup			16b. Kind of E		
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<u> a</u>	Suld be f Mental I arked of attc eve	2	7	VERLON	WHIT	E				FUJIKO	KIKU	CHI	
Maryland	2 should and Mer is marke raumatic		19a. Informant's Na	ame/Relationship (7	Type. Print)		19b. Mailir	ng Address (Street	and Number or R	ural Route Numb	er, City or Towr	n, State, Zip	Code)
	1 and 2 Health em 27 i		JUDITH	HARVEY-W	HITE/WIFE		4804	OGLETHO	RPE ST.,	RIVERDA	LE PARK	, MD.	20737
Baltimore,	Ø ○ ← ⊨		20a. Method of Disp 1 ☐ Burial 25 4 ☐ Donation		Removal from State	- 1		sition (Name of natory or other pla CREMATO		Date 10,2008	20c. Location	- City or To	
alti	permit. Pag Department Important: I any Injury o		21. Signature of Fu				22	. Name and Addre	ess of Facility				-
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	Physician /Medical		23a. Part 1. Enter the shock, or heal immediate Cause (disease or condition resulting in death)	rt tallure. List only o Final	olicati in that caused one cause on each li a. INTRACRA Due to (or as	ANIAL	Do not ent	er the mode of dyi					Approximate Interval Between Onset and Death
68760,	rtificate be executed by any physician and as the burial-transit and	Aedical Examiner	Sequentially list cor if any, leading to m cause. Enter Unde Cause (Disease or that initiated events resulting in death) I	nditions, mediate rlying injury	b. MALIGNAN  Due to (or as  c  Due to (or as	NT HYI	PERTEN ence of).	SION					
P.O. Box 6	The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal	death 3	Ectopic pregnand	гу			ate of deliver	ery Day Year
	ned ped e det	by P	Part II. Other signif	icant conditions co	ontributing to death b	ut not resul	ting in the u	nderlying cause giv	ven in Part I.	23e. Did	tobacco use cor	ntribute to th	ne cause of death?
ğ	quires en sign uld be	80	HYPER	RTENSION						1 🗆	Yes 2∏No	3 🔲 Prob	ably 4 🗌 Unknown
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tal	iclan: Th certificate ector, pag		25. Was case refer	red to medical					26 Place of Do	1 □ Yes ath (Check only	2 <b>X</b> No	1 ☐ Yes	2 ∐ No
>	Physiclan: r this certific ral director, p	To Be	examiner? 1 ☐ Yes 2√☐	No	Hospital:	ent 2□E	B/Outpatier	nt 3 DOA Oth		dome 5 ☐ Res		than (Cassif	
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4	To the within 2 To the comple	Σ	29b. Signature and	title of certifier	, , ,			29c. Licens	se number	_	29d. Date sign		
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	9		30. Name and addr	ess of person who d	completed cause of d	leath (Item :	23a) (Type,	00/ A	Spita	1 Dr	Che	VOV	14 MD
	Sta	to	31. Date filed (Mon	th, Day, Year)	32 Registr	ar's Signatu	ıre		1		- /-		1

State Registrar

OCT 1 0 2008

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 10 2008 50 V /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Garrett Friendsville 1628 Squire Fike Rd. 8. Date of Birth (Month, Day, Aug. 15, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number 6. Sex . 1922 **Funeral** Days Min. Months Hours 1 M 2 F Maryland Aug. 86 218-12-5710 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural"; or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he matter? 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 □,Yes 2 No Friendsville Directo Garrett MD 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21531 USA 1628 Squire Fike Rd. Funeral Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Baltimore, Maryland 21215-0036 Specify White ģ WW2 3 ☐ Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Roads Construction Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alice Umbel ပ္ Walter Humberson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2246 Washington Ave., Silver Spring, MD 20910 Jeffrey M. Humberson/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐Removal from State Country Side Crematory Oct. 9, 2008 Davidsville, PA 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Newman Funeral Homes, P.A. P.O. Box 275, Grantsville, MD 23a. Part1. Enterty e disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician -0 W /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in itilated events resulting in death) Last Dua to (or as a consequence of) Physician/Medical Examiner that the death certificate be executed burial-tran and Due to (or as a consequence of): Box 68760 the attending p for use as as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month in the past 12 months? 1☐Yes 2☐No 4 ☐ Pregnant at time of death 5 Other (specify) Ö the 9 Unknown 9 Unknown ed by t ۵. 23e. Did tobacco use contribute to the cause of death? signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No has page 2 certificate I 1□ Yes Division or Vital Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 ☐ ER/Outpatient 3□ DOA 1 Inpatient 1 ☐ Yes 2 this ...ospital or Attending Pt. in 24 hours after death. 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: (Month, Day Year) Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

VA State Registrar

31. Date filed (Month, Day, Year)

complete

30. Name and address of person while

32. Registrar's Signature OCT 2008

tause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 3. Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month **Physician** Oct. 2008 4:05 A<sup>M</sup> 12, Sally Jane Hardesty /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Garrett Mtn. Lake Park 809 M Street If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Numbe **Funeral** Days Months Hours Min. 1 ☐ M 2 ☐ XF Nov. 17, 1964 Maryland Director 215-96-2592 43 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County 1 ☐ Yes 2X No Director FLDe Soto Arcadia 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code o e with ural", or items 23a 5105 NW Oak Hill Avenue 34266 items 23a **United States** hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 No Maryland 21215-0036 Specify. þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: White 'natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 Elementary/Secondary (0-12) College (1-4or 5+) **Retail** Sales permit. Pages 1 and 2 should be filed Department of Health and Mental Hygin Important: If Item 27 Is marked other any injury or other traumatic event, # 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Murphy **Almeda Ellen Claude** Beckman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles M. Hardesty, Husband 5105 NW Oak Hill Avenue, Arcadia, FL Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 10/15/2008 Deer Park, MD Deer Park Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
David A. Burdock Funeral Home, 21 N. Second St., Oakland, MD Katherine Surether 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 11 months metastatic cervical cancer disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or injury that in list agents. Due to (or as a consequence of) Examine as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, nding physician certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death nse 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the aid o 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed 2 XNo director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certification: After 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident

Division or Vital Records, Hospital

il or Attending Fafter death. neral Director: / / filled in by the f within 24 hours a To the Funeral L

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 ☐ Could not be

3 ☐ Suicide

29a. Certifier

29b. Signatur

4 Homicide

(Check only one)

Richter, M.D. 1533 Memorial Drive Oakland, MD 21550 Donald R.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D30035

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

10-13-2008

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

State Registrar

1

Medical

and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 8

	-	For State Registrar	Otato or marytain	Cer	tificate of L	Death	1	Reg. No.	
		Decedent's Name (First, Middle, La	st)	11			2. Date of Dea	ith Day	3. Time of Death
Physici		Jeveminh	L. Hyw	iiiov			10/1	/2008	11:15 A M
/Medi Examir		4a. Facility Name (If not institution, gi	ve street and number)		4b. City, Town, or	Location of Death		4c. Count	y of Death
-		7638 Old Washir	ngton Rd.		Woodbir				roll
Funeral Director		Social Security Number     6.	Sex 7. Age (In yrs. I	as <i>t birthd</i> ay) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birl (Month, Da 12/29	h y, Year) /1930	9. Birthplace (State or Foreign Country)  MD
р		Usual Residence of Decedent	100 City	, Town or Lo	action				10d. Inside City Limits
arylar show	-	10a. State 10b. County							1 □Yes 🏖 📆 No
Ba-f	Director	MD Carrol	_ W	oodbin	e 10f. Zip Code			10a Citizen of	What Country?
vith th	Ö	10e. Street and Number	n 1		2179	7		rog. Onizon o.	USA
sath v	eral	7638 Old Wash:	12 Was Dagadant Ever in III	S. 13. V		/ lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No	- 14. Ra	ace - American Indian,
ter de	Funeral	11. Marital Status  1 ☐ Never Married 2 Married	Armed Forces?				Rican, etc.)		ack, White, etc.
al", or	þ	3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  1 1 Yes 2 No 1952  If Yes, Give Year or Dates: 1954	-	∐Yes 21⊠No	Specify:		Spec	"y: White
72 ho	eted	15. Decedent's E (Specify only highest gi	ducation	16a. Deced		during most of work	king	16b. Kind of I	Business/Industry
ILE IS-UUSO filed within 72 hours after death with the Maryland Hygiene. other than "natural", or Items 23a or 28a-f show ent, the Medicel Examinar nuest be rediffed at	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		oo not use retired chanic	d)			Auto
led w Hygiel her th	ပိ	17. Father's Name (First, Middle, Las	f)	rie	Chanic	18. Mother's Nam	e (First, Middle	Maiden Surna	
all c	Be	Jeremiah N. H				Rosie F	arver		
ryli hould id Me mark matic	은	19a. Informant's Name/Relationship		19b. Mailir	ng Address (Street	21010		er, City or Tow	n, State, Zip Code)
Manda Sid 2 so lith ar 27 is 27 is 1 trau		Shirley Hymil				ington Rd			
f Hear the other		20a. Method of Disposition	20b. F		sition (Name of natory or other place		Date		- City or Town, State
Pages ent of nt: If i		15□Burial 2 □ Cremation 3 d 4 □ Departion 5 □ Other (Spec		lar Sp	rings Cer	metery 10	/4/2008	Poplar	c Springs, MD
<b>BAITIMOTE,</b> INIGITYIATIO <b>ZIZIO-0030</b> permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Marical Examination and the traumatic event, the Marical Examination and prope.		21. Signature of Funeral Service Lice		3	Warre and Adde	ectriiTune	eral Hom	e & Cre	ematory, P.A.
<b>n</b> 88 5 8 8		Janu 4	) Chilly						ld, MD 21784
		23a. art1. Enter the disease, or colhock, or heart failure. List onl	mplications that cay sed the deat y one cause on each lim	h. Do not ent	er the mode of dyin	ng, such as cardiac	or respiratory a	rrest,	Approximate Interval Between Onset and Death
Physician		Immediate Cause (Final diseas condition resulting in death)	_a. / Con	gest	We H	cont	Fall	uve	1 year
/Medical Examiner		resulting in death)	Due to (or as a conseq	uffice of):	nic C	ardio	MIGH	aten	E VOLLES
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uted J ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							2
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r 68 artifica ing pl	-	IF FEMALE:							
BOX eath cer attendir for use	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnation 1 ☐ Live birth 2 ☐ Feta	Ideath 3	☐ Ectopic pregnand	су			Date of delivery Month Day Year
he de the street the street f	Physician/	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time of a 9 ☐ Unknown	jean 51	Other (specify) _				
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Vital R6 sician: The Is certificate ha irector, page 2	BeC	25. Was case referred to medical examiner?				26. Place of Dea	ath (Check only	one)	
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SiO teath. tor: A	cati	2 Accident investigat 3 Suicide 6 Could not		ome form st		]Yes 2□No	28f. Location	(Street and Nu	imber or Rural Route Number,
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Division of Vita Vita to the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director,		29a. Certifier Certifying	Physician: To the best of my kn	owledge, dea	th occurred at the	time, date and plac	e, and due to th	e cause(s) and	i manner as stated.
he Hc in 24 l he Fu pletel	Medical	(Check only 2 Medical Ex	aminer: On the basis of examin and manner stated.	auon and/of I	investigation, in my	opinion, death occ	and at the tille	on a Decision	Alanta Car Vacal
Vith To t	Σ	29b. Signature and title of certifie	Mat		29c. Licen	se number	11	29d. Date sig	ined (Month, Day, Year)
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10		30, Name and address of person who	no completed cause of death (Ite	m 23a) (Type	Print)	Blue. A	Flow.	sous 1	MD 21784
						- '			
	IND	31. Date filed (Month, Day, Year)	32. Regitrar's Sign	ature					
S Regin	tate tear	31. Date filed (Month, Day, Year)  OCT 0	32. Resittrar's Sign	ature	Corte	· · · · · · · · · · · · · · · · · · ·			in manner as stated.  the property of the cause(s)  gned (Month, Day, Year)  10, 01, 2-008  MN ) 11789

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 4:20 PM **Physician** October 2008 Mary Irma Hodges /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner St. Mary's St. Mary's Nursing Center Leonardtown Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 🖾 F 97 577**-**05**-**7877 March 6, 1911 Maryland Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Exprendent must be retified at once. 1 ☐ Yes 21 No Director Maryland St. Mary's Avenue 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 23275 Colton Point Road 20609 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after or the filed within 72 hours after or the alth and Mental Hygiene. 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ∐Yes 2 ⊠No White Specify Specify: ρ 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Office Clerk Union 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Catherine Dove Russell ပ William Lee Owens 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 23263 Colton Point Road Avenue, MD 20609 Lois Ruth Grogan Morris / Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition October 17 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Bushwood, Maryland Sacred Heart Cemetery 2008 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P P.O. Box 270 Leonardtown, MD 20650 ener Approximate Interval Between Onset and Death 23a. Part 1 Enter the disease, or com shock, or heart failure. List only complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician V/25 /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examine Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 M Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fi 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and itle of certifier 29c. License number 10.17-08

State

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William D. Boyd II, M.D.

08-07723 Anthony Tyre	one	Hav						ndelible artment						gible		00	0 0000
			I- For State Registrar 1. Decedent's Name				•	rtificate (					_	Reg. No.		UU	8 3 3 8 3 9 3. Time of Death
Phys Medical Ex		ner	Anthon	y Tv	rone	Hav	kins	Jr			•		Month October		Yea 08	г	1715 hrs
			4a. Facility Name (i 5191 Harris	f not institution	on, give stre	et and num	ber)		4b. City, To Rock I		Location of	Death			County of Cent	of Death	
Fune Direc			5. Social Security N		6. Sex		. Age (In yrs.	last birthday)	If Under Months			24Hrs. Min.	8. Date of B	•		Cou	hplace (State or Foreign untry) estertown
	any		Usual Residence of	f Decedent			10c. City	, Town or Loc	ation								10d. Inside City Limits
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Maryla	s 23a or 28a-i snow a notified at once	Director	10e. Street and Nu		D 1				10f. Zip (						zen of Wh	nat Coun	itry?
with the	e notifi	eral D	5191 Hat	rris		Was Dece	dent Ever in U			nt of His			ecify Yes or N	US.		- Americ	can Indian, Black,
death	or rem	Fune	1 Never Marri		1	Armed For Yes	ces? 2X No		f Yes, specify			Puerto F	Rican, etc.)		White		
ırs afteı	miner	2	3 Widowed  15. Decedent's Ed		vorced or Decify only hi		completed)		Yes 2			ind of w	ork done	16b.	Specify: Kind of Bu		
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5-0036 led within 7 Hygiene.	ther th	mo.	1 Z E II	(First, Middle	, Last)			Stor	e-ro		-		(First, Middle,				U.M. Hm
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Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.	nt: If item 2/ is marked other than "natural", other traumatic event, the Medical Examiner	٩	19a. Informant's Na Anthony				r fat						ural Route Nu Rock				
re, N s I and f Health	II item		20a. Method of Dis		n 3 🗆 E	emoval from		Place of Disp crematory or			metery,		Date	20c.	Location -	- City or	Town, State
Baltimore, permit Pages I an Department of Hea	rtant:		4 Donation 5	Other S	pecify:			aron C	hape]				21-08	R	ock	Ha1	1, MD
Bal permi Depar	mpor	U.	21. Signature of Fu	ineral Service	7/2	wes	)	L		_	s of Facility	FH	- Bt	298	w	orto	n. MD 2167
Physic /Medi			23a. 1. I. Enter the		on each li	ne.		h. Do not ente	r the mode o		such as ca	rdiac or	respiratory a	rrest, sh	ock, or he	art	Approximate Interval Between Onset and
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Box 6	e attend for use	.22	1 Yes 2		iknown g	-	nt at time of d vn	leath 5	Other (Spec	cify)				Ï			N.
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death.	After this certificate has been signed by the funeral director, page 2 should be detached f	by Phy	Part II. Other sign		tions con	tributing to	death but not	resulting in th	e underlying	cause	given in Par	rt i.		_			the cause of death?
ds, F	ould be												24a. Wa	s an	24b.	Were au	topsy findings available
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Divisior To the Hospital or Attend within 24 hours after death	Funers tely fill		4 Homicide 29a. Certifier (Check only				of my knowle	dge, death oc	curred at the	time, d	ate and pla	ce, and	due to the ca	use(s) a	nd manne	r as stat	ed.
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			30. Name and add														
		o to	Carol Allan					111 Pen	n Street, E	Baltim	ore, MD	21201	1				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Department of Health a 1- State Registrar amend #19a Per INF G884 10/23/08 JH Certificate of Death	and Ment	al Hygien Reg. N	e 2008	3 3 3 8 4 0
			1. Decedent's Name (First, Middle, Last)		ate of Death	V	3. Time of Death
6/10	Physicia /Medic	_	Joyce Elaine Joyner	1	0 06		YINY AM
	Examin	er	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of			c. County of Deat	
-	Sign Comments		Ft. Washington Hospital Ft. Washing  5 Social Security Number 6 Sex 7 Age (In vis. last birthday) If Under 1 Year If Under 2		ate of Birth	Prince G	-
)	Funeral Director		577-58-4472 1 M 2 X F 63 Yrs. Months Days Hours	Min (N	22/1945	r) Co	thplace (State or Foreign ountry) A
	, v	ŀ	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	short short	5	MD Prince George's Oxon Hill				1½ Yes 2 □ No
	the N 28a-f	ect	10e. Street and Number 10f. Zip Code		10a. C	Citizen of What Co	ountry?
	with a or	듑					,
	eath	era	1809 Mystic Ave.  11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Original If Yes, specify Cuban, Mexican			S.A. 14. Race - Ame	erican Indian,
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	Armed Forces? If Yes, specify Cuban, Mexican 1 □ Never Married 2 □ Married 1 □ Yes 2 □ No If Yes, Give 1 □ Yes 2 □ No Specify: Year or Dates:		ı, etc.)	Black, Whit	
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Maryland	d be file intal Hy ed oth	Be	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	er's Name <i>(Firs</i> .ine Jo1	et, Middle, Maide cdan	n Surname)	
7	should nd Me mark matic	욘	19a Informant's Name/Relationship (Type Print)  19h Mailing Address (Street and Number	er or Rural Rou	ıte Number, City	or Town, State,	Zip Code)
<u>≅</u>	nd 2 string at trau		Sheri E. Boyd/daughter 15227 Chase St., Un	nit 14,	North	Hills,	CA 91343
ē,	s 1 ar f Hea <b>Item</b>		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date		Location - City or	
m 0	Page: ent o nt: If ry or		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)  Ft. Lincoln Cemetery	10/11/2	2008 Br	entwood	, MD
Baltimore,	permit. Departm Importal any Inju		21. Signature of Funeral Service Licensee 22. Name and Address of Facility 3401 Bladensburg	ty Ft. L	incoln	F. H.	
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	Hospita 4 hours Funeral	Medical C	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date an 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dea and manner stated.				
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	7		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	المراسخ	KIN W	Pa In	フケン
		ate	31. Date filed (Month, Day, Year)  OCT 0 9 2008  32. Registrar's Signature	3	÷ ,		, ,
	Regist	rar	UCI U J. Comp.				

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	/Medic	cal	Isabel Victoria Jones  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	10 0	8 2008 4c. County of Death	1630
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П	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthdo		8. Date of Birth (Month, Day, Ye	9. Birthr	place (State or Foreign
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	/land ow at		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or	Location		1	10d. Inside City Limits
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	e filed within 72 hours after death with the Maryland Hygiene. other than "natural", or Items 23a or 28a-f show vent, the Medical Examiner must be notified at	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Cour	
	s 23a	Funeral	57 Jackson Street  11. Marital Status   12. Was Decedent Ever in U.S.   1	21539	acifu Vac or No	14. Race - Americ	SA Can Indian
0	ifter d		1 □ Never Married 2 □ Married 1 □ Yes 2 1 No	<ol> <li>Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto</li> </ol>	Rican, etc.)	Black, White,	
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and	e filed al Hyg other	Be Completed	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, Maid	den Surname)	
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	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If if health and Mental Hygiene. If if the 27 is marked other than "natural", or items 23a or 28a-f show if it item 27 is marked other than "natural", or items is be notified at or other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Type. Print)  Ed Jones - Son	lailing Address (Street and Number or Run 15205 New Georges Cre			· ·
<u>၈</u>	s 1 and 2 f Health item 27 i		20a. Method of Disposition 20b. Place of Di	sposition (Name of	Date 200	c. Location - City or To	
altimor	Pages nent of I int: If ite		Industrial 2   Cremation 3   Helitoval Itolii State	stburg Memorial Park	October 11, 2008	Frostburg	, Maryland
Salt Salt	permit. Pages Department of Important: If It any Injury or once.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility	Eichhorn	-McKenzie Fu	neral Home P.A.
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(AP)	Noveleien.		23a. Par1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.  Immediate Cause (Final				Approximate Interval Between Onset and Death
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- 5	pa isit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
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DIVISION	Attending r death. ector: After by the funer	icati	254 Accident investigation /0/21/8 16	30 PM 1 □ Yes 3 No	28f. Location (Stree	t of wheel	
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	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	and manner stated.	29c. License number			
	7. vii		29b. Signature and title of certifier	D 25 406		Date signed (Month,	
			30. Name and address of person who completed cause of death (Item 23a) (Ty)	pe. Print)			•
		$\stackrel{>}{\sim}$	WILLIAM LAMM GOO SETON	J Peive , COMBER	1, DUANS	4D 2150	2
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	Dhysisi		1. Decedent's Name (First, Middle,	Last)					2. Date of De Month	Da	y Year	3. Time of	
١.	Physici /Medio		Harold Raymond K						Octobe	r 3,	2008	7:30	A <sup>M</sup>
	Examir	er	4a. Facility Name (If not institution, g				4b. City, Town, or		ath	40	. County of Death		
	and the same of th		Goodwill Mennoni  5. Social Security Number 6		(In yrs. last bi	irthday)	Grantsvi		rs. 8 Date of Bird	th	Garrett	lace (State or	r Foreian
	Funeral Director		220–10–0897 Usual Residence of Decedent	1 <b>½</b> M 2□ F	93		Months Days	Hours Mi		y, Year) , 19	15 Mary	n <u>tr</u> y)	roreign
	land ow		10a. State 10b. County		10c. City, Tov	vn or Lo	cation				1	0d. Inside Cit	y Limits
	Mary -f sh	ţo	MD Garret	+	Acci	iden	ıt.					1 ☐ Yes	2 📉 No
	r 28a	Director	10e. Street and Number				10f. Zip Code			10g. Cit	tizen of What Cour	ntry?	
	th wit	aD	2849 Bumble Bee	Rd.			21520			USA	4		
	r dea	Funeral	11. Marital Status	12. Was Decedent 8 Armed Forces?	ver in U.S.	13. \	Was Decedent of H If Yes, specify Cuba	ispanic Origin? an, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	)-	<ol> <li>Race - Americ Black, White,</li> </ol>		
Maryland 21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	ē	1 ☐ Never Married 2 ☐ Married 3 🏿 Widowed 4 ☐ Divorced	1 ☐ Yes 2 <b>X</b> N If Yes, Give Year or Dates:	lo		1 ☐ Yes 2 🛣 No	Specify:			Specify: Wh:	ite	
5 - -	72 hc 'natu	Completed	15. Decedent's (Specify only highest	Education grade completed)	16a	a. Deced (Give	dent's Usual Occup kind of work done o DO NOT use retired	ation during most of v	vorking	16b. K	(ind of Business/In	dustry	
2	/ithin ne. han "	ם	Elementary/Secondary (0-12)	College (1-4or 5						Mare	uland cu	٠	
N D	iled v Hygie ther t	ပိ	17. Father's Name (First, Middle, La	st)	пе	avy	Equipmen		lame (First, Middle		yland SHA Surname)	3	
aŭ	0 = 0 %	Be	John Kahl	0.7				Laura 1		,	,		
2	shouls nd Me mark matte	ဥ	19a. Informant's Name/Relationship	(Type. Print)	19	b. Mailir	ng Address (Street	and Number or	Rural Route Numb	er, City	or Town, State, Zip	Code)	
	nd 2 salth all		Harold J. Kahl/S	Son	13	180	Thompson	Ct., St	t. Leonar	d, N	1D 20685	,	
Ē,	s 1 a of Heg item othe		20a. Method of Disposition	-	20b. Place o	of Dispo	osition (Name of matory or other place	ce)	Date	20c. L	ocation - City or To	own, State	
altimore,	Page nent c ant: If ury or		1  Burial 2  Cremation 3  Cremation 3  State  Special  Special  Cremation 5  State  Special		Lutl	heran Cem	etery C	ct. 6, 2					
Balt	permit. Pages 1 and 2 should be Department of Health and Mente Important: If item 27 Is marked any Injury or other traumatic en		21. Signature of Funeral Service Li	ensee					Newman Fu antsville			P.A.	
			23a. Part1. Enter the disease, or co shock, or healt ailure. List or		the death. Do	_						Approximate Interval Bety	e ween
o'a	Physician	0.7	Immediate Cause (Final disease or condition						NARY 1		chec	Onset and L	Death
	/Medical		resulting in death)	a. Due to (or as	a consequence	of):		FRUM	Jan Jan	110	CALATA.		
k	Examiner	ш	Sequentially list conditions	b									
	<u>+</u>	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		d Consequence	of,							
	ecute and -trans	Examiner	that initiated events resulting in death) Last	C	a consequence	of)-							
68760,	icate be executed physician and s the burial-transit			Due to (or as	a consequence	5 OI).							
387	physicate sthe	Medical	`	d									
_	certificanding plans as t	/We	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome							23d. Date of deliv	ery	
P.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician//	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1□Live birth 4□Pregnant at 9□Unknown			_Ectopic pregnancy ☐ Other (specify)	/			Month	•	/ear
	s that ned b	by Pt	Part II. Other significant condition	s contributing to death be	ut not resulting	in the u	nderlying cause giv	en in Part I.	23e. Did 1	tobacco	use contribute to t	he cause of d	eath?
<u>5</u>	quires in sign		CHROWI	- RENAL	INSU	15	CENENCY		_ 1 🗆	Yes 2	Pro 2 □ No 3 □ Pro	bably 4	Inknown
Records,	aw requir s been si 2 should	Completed					\		24a. Was		24b. Were auto	opsy findings a	available
	Physician: The lav this certificate has al director, page 2 a	E							— auto perfo 1⊟ Yes	psy ormed? 2 <b>X</b> N	death? o 1 ☐ Yes	2 □ No	ause oi
ita	lan: artifica	Bec	25. Was case referred to medical examiner?					26. Place of [	Death (Check only				
<u>-</u>	Physician: r this certificaral director, praise of the control of	2	1 Yes 2 No	Hospital: 1 ☐ Inpatie	nt 2 ER/0			4 Nursin	g Home 5 ☐ Res	idence	6 ☐Other (Speci	fy)	
u 0	ing P		27. Manner of Death  1 □ Natural 5 □ Pending	28a. Date of Inju (Month, Day		. Time o Injury	Wor		28d. Describe	how inju	iry occurred		
Sio	Attending r death. ector: After by the fune	cati	2 Accident investiga 3 Suicide 6 Could no	the !				Yes 2 ☐ No	000 1			10-1-11	
Division or Vital	or At after d Direc in by	ertification:	4 Homicide determin		o. (Specify)	rarm, str	reet, factory, office		City or To	wn, Stat	nd Number or Rur le)	ai Houte Num	per,
	spitai ours a neral filled	O	29a. Certifier Certifying	Physician: To the best	of my knowledg	ge, deat	h occurred at the ti	me, date and pl	ace, and due to the	cause(s	s) and manner as	stated.	
	To the Hospital or Attending Phys within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral di	edical		caminer: On the basis of and manner sta	examination a								5)
	To th withir To th comp	Me	29b. Signature and title of certifier				29c. Licens	e number		29d. Da	ate signed (Month,	Day, Year)	
			) Ita	ehi			D26	907		00	3 852 3	2008	>
		6	30. Name and address of person w	no completed cause of d	eath (Item 23a)	) (Type,		+			,		
		(	Dr. Harjit S. Si		925 Bisar's Signature	shop	Walsh Ro	d., Cum	berland,	MD	21502		
	Sta Regist		31. Date filed (Month, Day, Year)  OCT - 7	167	ara arginature	1	Comette 2						

DHMH 17 Rev 1/2001

**O**RIGINAL

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** October 11:05 AM Kalnasy Patricia 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Hospital Leonardtown St. Mary's 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🔀 F Months Days Hours Min. Director 579-48-1881 74 April 15,1934 Washington, DC Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the "Modical Expuring trust be notified at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 X No Directo St. Mary's Maryland Leonardtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 41735 Eldon Court 20650 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2x No Specify Completed by Specify: 3K Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) St. Mary's Hospital 12 Accounts Payable Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Schilke Reithmever Martha မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George Kalnasy, Jr./ Son 23305 Maypole Road, Leonardtown, Maryland 20650 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Charles Memorial Grd. 10/20/2008 Leonardtown, Maryland 22. Name and Address of Facility Brinsfield Funeral Home, P.A. dure of Funeral Service License Edward N. Brinsfield 22955 Hollywood Road, Leonardtown, MD 20650 **♂r**.M00052 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ARDIAC 14 hours disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): The law requires that the death certificate be executed Stole IV Serve Due to (or as a consequence of): and burial-trar resulting in death) Last Box 68760, attending physician for use as the buria Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the a d be detached for o 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown should cate has been s , page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform this certificate Vital 1 ☐Yes 2 ☐ No i□Yes 2 X No or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 patient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To o To the Hospital or Attending Phywithin 24 hours after death.

To the Funeral Director: After thicompletely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred Division Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only and manner stated. 29b. Sig 29c. License number 29d. Date signed (Month, Day, Year) 2008 nd address of person who completed cause of death (Item 23a) (Type, Print) Box MONDES. Th KOAche 31. Date filed (Month, Day, Year) 32. Registr ar's Signature State Registrar

DHMH 17 Rev 1/2001

**ORIGINAL** 

State Registrar

RAHIMIANOMO

31. Date filed (Month, Day Year)

10

10403

32. Registrar's Signature

Hospital Drive

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State Registrar	State of Ma	aryland		rtment of F	lealth and N Death	/lental Hy	/giene Reg. No.	200	8	338	845
	Discolate		1. Decedent's Name (First, Middle, I				2. Date of De Month	Day		ar	3. Time of			
	Physicia /Medic		Charles Robert I				Oct. 7				1:55	Рм		
	Examin	er	4a. Facility Name (If not institution, g	*	r Location of Death			County of D						
			Holy Cross Hospi		e (In yrs. las	et hirthday)	Silver S	pring If Under 24 Hrs.	8 Date of Bi		ntgom			or Foreign
	Funeral Director		214-32-7875	1 M 2 F	73	Yrs.	Months Days	Hours Min.	8. Date of Bi (Month, D June 11	ay, Year) 1,193	5		lace (State o try) yland	
	pu *	1	Usual Residence of Decedent  10a. State 10b. County		10c. City.	Town or Lo	cation					10	0d. Inside Cit	ty Limits
	taryla f sho	5		George's		svil]							1 🏿 Yes	2 □ No
	28a-	Directo	10e. Street and Number	dealge b	11) (10)		10f. Zip Code			10g. Citiz	zen of Wha	t Coun	try?	
	3a or		4701 40th Avenue	<u>.</u>			20781			USA				
	ms 2	Funeral	11. Marital Status	12. Was Decedent I Armed Forces?	Ever in U.S.	13.	Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or N	0-	14. Race - A			
36	be filed within 72 hours after death with the Maryland Hygiene. d other than "natural", or items 23a or 28a-f show event, it a historial Examinar must be notified at	by Fu	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced		Vo		1 □Yes 2⊠No	Specify:	, i noun, oto.)		0	Whi		
Ö	2 hou	ted	15. Decedent's	Education		16a. Dece	dent's Usual Occup	oation	e la com	16b. Kir	nd of Busin	ess/Inc	lustry	
215	e. an "na Madi	Be Completed	(Specify only highest Elementary/Secondary (0-12)	college (1-4or 5+)			DO NOT use retire	*	_					
21	should be filed within nd Mental Hygiene. marked other than imatic event, II e M	Son	12			Servi	e Techni	cian / Er				lowe	11 Cor	<u>ср.</u>
p	0 -		17. Father's Name (First, Middle, La	•				18. Mother's Nam		,	Surname)			
<u>ya</u>	should be and Mental s marked o	၉	Robert Reginald								. T 04-	7:-	0-4-1	
Maryland 21215-0036	2 serial		19a. Informant's Name/Relationship Mary A. LaQuay					and Number or Ru nue, Hyat					Code)	
e)	1 and Health em 27 ther t		20a. Method of Disposition	MILE	20b. Pla				Date		cation - Cit		wn, State	
Baltimore,	Pages nent of int: If Its iry or o		1 ₺ Burial 2 ☐ Cremation 3								phi.	Mar	yland	
₹	artme ortan Injur		4 □ Donation 5 □ Other (Special Signature of First ral Service Lie		OCOLE		2. Name and Addre	-	.,		_			702210
B	permit. Departr Importa any inju		Jan 14	4		Ga	sch's Fu	neral Hom	ne, P.A.	473 Hya	y bai ttsvi	11e	ore Av , MD 2	20781
			23a: Part1. Enter the disease, or co shock, or heart failure. List or	omplications that caused	the death.	Do not en	er the mode of dy	ng, such as cardiac	or respiratory	arrest,			Approximate Interval Bet	e tween
1	Physician		Immediate Cause (Final disease or condition			Cerebi	covascula	ır Accider	nt				Onset and I	Death
	/Medical		resulting in death)	Due to (or as										
	Examiner		Securatially list conditions	<sub>ь.</sub> Coumadi	b. Coumadin Induced Coasulopathy  Due to (or as a consequence of):									
	ed sit	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	ence ot):									
_	xecut and II-tran	Examiner	that initiated events resulting in death) Last	c Due to (or as	a conseque	ence of):						+		
68760,	ficate be executed physician and s the burial-transit													
687	ificate g phy as the	edical		u.										
Вох	leath certific attending p	M/u	IF FEMALE; 23b. Was decedent pregnant	23c. If yes, outcome			∃Ectopic pregnan	cv			23d. Date o			.,
O. B	deat he att	Physician/M	in the past 12 months? 1 ☐Yes 2 ☐ No	4 ☐ Pregnant a 9 ☐ Unknown			Other (specify)				Month	1	Day `	Year
<u>Р</u>	at the ded by the stached	Phy	9 ☐ Unknown  Part II. Other significant condition		t mat vaavilt	time in the u	ndorbina acuso ai	von in Part I	23e Did	tobaccou	ise contribi	ite to th	he cause of c	death?
Division of Vital Records,	The law requires that the death certificate be executed ate has been signed by the attending physician and age 2 should be detached for use as the burial-transit	þ	Part II. Other significant condition	s contributing to death b	out not resum	ung in the t	rideriying cadse gi	ventin raitt.					oably 4 🔀 I	
00	w require s been si should b	Completed							24a. Wa	s an	24b. We	re auto	psy findings	available
æ	he law e has	dmc							per	opsy formed?	dea	ith?	mpletion of c 2 □ No	ause of
ta	ysician: The iis certificate hidirector, page	BeC	25. Was case referred to medical					26. Place of Dea		2⊠No one)	'-	1165	2 🗆 140	
<u> </u>	iysici iis cel direc		examiner? 1 ☐ Yes 2 ☐ No	Hospital:	ent 2 🗆 E	R/Outpatie	nt 3 □ DOA Ot	her: 4  Nursing H	ome 5 Re	sidence	6 □Other	(Specil	fy)	
0	ding Phys h. After this funeral di	L:uc	27. Manner of Death 1 ☒ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da		28b. Time o Injury	f 28c. Inju	ıry at rk?	28d. Describe	e how injur	y occurred			
Sio	tendli eath. or: A the fu	catic	2 Accident investiga	the		-		]Yes 2□No						
Ξ	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director;	Certification: To	4 Homicide determin	ad Zoe. Flace of III)	jury - At hon tc. <i>(Specify)</i>		reet, factory, office		28f. Location City or To	ion (Street and Number or Rural Route Number, or Town, State)				
	spital ours a neral I		29a. Certifier 1 ☑ Certifying	Physician: To the best	of my know	rledge, dea	th occurred at the	time, date and place	and due to th	ne cause(s	) and manr	ner as s	stated.	
	n 24 h	Medical	(Check only 2 Medical E	kaminer: On the basis of and manner st		on and/or i	nvestigation, in my	opinion, death occu	irred at the time	e, date and	d place, and	d due t	o the cause(s	s)
	To th To th comp	Me	29b. Signature and title of certifier		1	_	29c. Licen	se number					Day, Year)	
	6		XX (000)41	Laneu. 1	MI	)	D672	79		1	10/09	/200	)8	
	IVA		30. Name and address of person w	ho completed cause of	death (item	23a) (Type,	Print)		dere D	1 + 4	3 M C 3/11	n 11	1227	
			Suganthi Alagar	-	pan, rar's Sigratu		ranklin :	square Dr	rve, Ba	ILIMO	re M	J Z.	1231	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 10 06 Day **Physician** 2008 8:55a Doris J. Marceron /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Garrett Dennett Road Manor Nursing Home 0akland If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex **Funeral** Days Hours 1 □ M 2 🖺 F Months 02/05/1913 579-14-5939 95 Washington, DC Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County or than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 AYes 2 No Director Maryland Garrett 0akland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code filed within 72 hours after death with 1083 Lake Shore Drive 21550 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 ▼No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No White Specify Specify: ð 3 NWidowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me College (1-4or 5+) Homemaker Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Grace Erhardt Edgar T. Grigsby ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan Schelling Lake Shore Dr., Oakland, MD21550 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Cemetery 10/13/2008 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fugeral Service Licensee 22 Name and Address of Facility Fort, Lincoln Funeral Home 3401 Bladensburg Rd., Brentwood, MD 20722 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) PSIS **Physician** /Medical Due to (o as a consequence of): Examiner dementia advanced Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner The law requires that the death certificate be executed the burial-trar Due to (or as a consequence of): Box 68760, attending physician for use as the buria IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 mg Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death P.O. I ned by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, s been signe should be d Completed by 1 ☐ Yes 2 No 3 Probably 4 nknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an was ...
autopsy
performed?

ves 2500c page 2 s 1∐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Medical Certification: To 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural
2 ☐ Accident 5 ☐ Pending investigation ours after death.
neral Director: Al 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral I

completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

State Registrar

DHMH 17 Rev 1/2001

cause of death (Item 23a) (Type, Print)

2008

29c. License number

29d. Date signed (Month, Day, Year)

gewell highway oakland, eld 2155

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrat Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** Markowitz Benton Louis 2008 8:10P. M October /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 9817 Sailfish Terrace Montgomery Montgomery Village If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye Nov. 5, 1941 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Days Connecticut 049-34-0518 1 X M 2 □ F 66 Hours Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d Inside City Limits 10a. State 10b County 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, it of Medical Expanications be notified at 1 XYes 2 No Montgomery Village Director Maryland Montgamery 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? death with 20886 United States 9817 Sailfish Terrace Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 □Yes 2 No White If Yes, Give Year or Dates: Specify Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. Accountant private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Markowitz Mildred Alper ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any injury or other trau once. Greta Bader -sister 11120 Mountain View Lane Ijamsville, Maryland 21754 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 □ Cremation 3 □ Removal from State Garden of Remembrance 10/7/2008 Clarksburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Bonala Vode Borgwardt Funeral Home, PA Daniel 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Atherosclerotic Cardiovascular Disease 10 years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Diabetes 10 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours effer death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriah-transit completely filled in by the funeral director, page 2 should be detached for use as the buriah-transit 10 years Hypertension Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Lipidemia 10 years Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been significate has been significated by page 2 should by Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑No 24a Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 1 Yes 2 X No ဥ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) October 6, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael Greene, M.D. 19640 Clubhouse Road, #410 Montgomery Village, Maryland 20886 31. Date filed (Month, Day, Year) OCT 0 9 32 Registrar's Signature State 2008 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 10 /Medical 4a. Facility Name (If not institution, give street and number 4b. City. Town, or Location of Death 4c. County of Death **Examiner** BACTIMORE (LAM) MED 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Sex Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 🙀 F 546-32-1252 83 Director 09/25/1925 California Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner nust be notified at 1 ☐ Yes 21 No Directo Maryland \_Anne Arundel Riva 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number "natural", or items 23a or 3220 Breckenridge Way Completed by Funeral 21140 USA 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐Yes 2 X No Baltimore, Maryland 21215-0036 Specify: Mexican 1X Yes 2 □ No Specify: Hispanic 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event any order." Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Factory Worker Canning 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gumecindo Blanco Angela Prieto P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lorraine Hanley / Daughter 3220 Breckenridge Way, Riva, Maryland 21140 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 10-04-08 Edgewater, Maryland Kalas Crematory 21. Signature of Funoral Service ace 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd., Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DAVS **Physician** INTRACRANTIAL HEMORRHAGE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 No Month 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u>≽</u> 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury UNK M 15 08 1 ☐ Yes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3230 BRECKEN RIDGE WAY determined 4 Homicide HOME MD RIVA 21140 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. 29a. Certifie Medical (Check only one) DKan, DO 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 010220180 5 W 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) 22 KIM  $\mathcal{D}O$ S. GREENE DANTE 31. Date filed (Month, Day, Year) 32\_Registrar's Signature State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Registrar

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** /Medical Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death County of Death Examiner sarret 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) West Virginia 5. Social Security Number **Funeral** Days Hours Min 2 🗆 F 216-30-1906 Director Usual Residence of Decedent permit. Peges 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Intriportant: If Item 27 is marked other than "natural", or Iteme 23a or 28a-f ehow any Injury or other traumatic event, the Medical Experiment. 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits ty Yes 2 No Director MD Mtn. Lake Park Garrett 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? (Apt. 19) 21550 607 N Street United States Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black White etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 1 ☐ Yes 2X No ģ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Coal Miner Coal 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Sommerville Walter Ε. Maule Catherine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald Stewart, Nephew 912 Foxtown Rd., Accident, MD 21520 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State tX Burial 2 ☐ Cremation 3 ☐ Removal from State 10/16/2008 4 ☐ Donation 5 ☐ Other (Specify) Pleasant Valley Cemetery Oakland, MD 22. Name and Address of Facility David A. Burdock Funeral Home, P.A. 21 N. Second St., Oakland, MD 21550 21. Signature of Funeral Service Licenses Katherine 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner attending physicien and for use as the buriel-transit Hospitel or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? cate has been significant categories. 1 Yes 2 No 3 Probably 4 Munknown 24b. Were autopsy lindings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 No 1 Yes uneral director Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 XNo 1 Npatient Medical Certification: To 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 ☑Natural 2 ☐ Accident 5 Pending efter death.

I Director: Aff
d in by the fur 1 Tes 2 No investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide within 24 hours e To the Funeral D completely filled i 29a. Certifier 1 🐹 Certifying Physician: To the best of my knowledge, death uncurred at the time, data and place, and due to the cause(s) and marrier as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature aroutitle of certifier

Division of Vital Records. P.O. Box 68760

State Registrar

31. Date filed (Month, Day, Year)

M.D. .

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Daniel Buckingham, 255 N. Fourth Street. Oakland, MD

32. Registrar's Signature

2008 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Day Year Kenneth Milton Martin 2008 October 4, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Greater Baltimore Medical Center Towson Baltimore If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth Month, Day, Year) Apr. 5, 1940 5. Social Security Number 7. Age (In vrs. last birthdav) Birthplace (State or Foreign Country) **Funeral** Months 1 X M 2 □ F 212-48-6031 68 Yrs. Apr. Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location show "natural", or items 23a or 28a-f sho Director Maryland Carroll County Manchester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21223 Gunpowder Road 21102 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married altimore, Maryland 21215-0036 1 □Yes 2X No Completed by Specify: Specify: white 3 Widowed 4 Divorced er than "natura", I've Medical P 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) none none 7 is marked othe traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ss 1 and 2 should be fill of Health and Mental Hitem 27 is marked out Be Harry Milton Martin Mildred Mae Kemp 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fugenia Atkins - sister 1213 Cathedral Circle Madison, Alabama 35758 permit. Pages 1 and 2 Department of Health Important: If item 27 any Injury or other tra once. 20b. Place of Disposition (Name of cemetery crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State oct. 9, 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Forest Ridge Cemetery Upperco, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Fline Funeral Home M01072 934 South Main Street Hampstead, Maryland 21074 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Sepsi's /Medical Due to (or as a consequence of) Examiner Hodakins Lymphorna Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Attending Physician: The law requires that the death certificate be executed g physician and is the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical s been signed by the attending p should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Feta! death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an this certificate has all director, page 2 s autopsy performed? 1 ☐ Yes 2 DINO e Hospital or Attending Physician: 24 hours after death. e Funeral Director: After this certific letely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 2 No 1 ☐ Yes Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

5:00

10d. Inside City Limits

Approximate Interval Between Onset and Death

Year

29d. Date signed (Month, Day, Year) 1014/08

1 ☐ Yes 2 🔀 No

To the Hosp within 24 hou To the Fune completely fi WJL 3+1

Cynthia Soriano MD 31. Date filed (Month, Day, Year) 00108

29b. Signature and title of certifier

Cyuthna

29a. Certifier

(Check only

Medical

6701 N. Charles St Balhmore MD 21204 32. Registrar's Signature

on au in

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

DU051347

State

Registrar

Amended Items 26 & 27 per Phy. 10/07/2008 Carroll County, wjl Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Kathryn Riley Mathias October 4, 2008 4:55 a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Westminster Carroll 32 Center Street 8. Date of Birth (Month, Day, Year) Jul 22, 1908 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months 1 ☐ M 2 🗙 F Pennsylvania 100 213-38-6065 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at Westminster 1 XYes 2 □ No Carroll Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21157 USA 32 Center Street Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Specify Specify: white þ 3 ₩ Widowed 4 Divorced Year or Dates: Completed 16b. Kind of Business/Industry the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Schools Teacher permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important; If Item 27 Is marked other any Injury or other traumatic event, i 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna Cowling John J. Riley ပ 19a. Informant's Name/Relationship (Type. Print) Step 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15595 Walton Heath Row, San Diego, CA 92128 Mary Ellen Carosella, Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Westminster Cemetery 10/10/2008 Westminster, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Myers-Durboraw Funeral Home 21. Signature of Funeral Service License Willis Street, Westminster, MD 21157 proximate erval Between nset and Death 23a. Parti) Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-tran Due to (or as a consequence of): Physician/Medical use as the IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? ρ Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death detached 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 1 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performet? 1 Yes 2 No director, 25. Was case referred to medical 26. Place of Death (Check only one) Certification: To Be examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA funeral ( 28a. Date of Injury (Month, Day Year) 27. Manner of Deat 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year)

Box 68760. attending physician death certificate be P.O. I signed by the a Division or Vital Records, been si cate has I certificate or Attending Physician: this To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director; After th completely filled in by the funeral

with the Maryland

filed within 72 hours after death

"natural", or

and Mental Hygid Is marked other

and

Maryland 21215-0036

Baltimore,

WJL 6+4 29b. Signature and title of certifier

(Item 23a) (Type, Print) 30. Name and address of pe

manchester, MD 21102 W 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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		1- For State		Certific	cate of I	Death	_				Reg. I			0 0000
Physici	an/	Registrar  1. Decedent's Name (First, Middle,Last)  2. Date of Death Month Day Year September 30, 2008										3. Time of Death 0755 hrs		
dical Exam	iner	DOMECTIC TATE									of Death	07001113		
		4a. Facility Name (if not institution Carroll Hospial Center	b. City, Town, or Location of Death  Westminster						Carroll					
			rthday)	if Under 1		lf ⊍nder	24Hrs.	8. Date of	Birth (	MM/DD/YYYY	g. Birth	place (State or Foreign		
Funeral Director		5. Social Security Number		Age (In yrs. last bi			Days	Hours	Min.	Oct	15	1958	Cour	ntry) MD
Director		216-70-0691	1 X M 2 F	49	Yrs.			1.11		acc.	10		<del></del>	
Į,		Usual Residence of Decedent  10a. State  10b. County		10c. City, Tow	n or Locatio	n								10d. Inside City Limits
ow at		MD Carroll Finksburg									1 Yes 2 X No			
yland a-f sh t once	tor	10e. Street and Number	LIOIL	10f. Zip Code							10g.	Citizen of Wi	nat Country?	
ith the Maryland 23a or 28a-f show any notified at once.	Director	1695 Hoff Land	_			2	104	8			1	τ	JSA	
ith th 23a notif		11. Marital Status		ent Ever in U.S.	13. Was	Decedent			n? (Spe	cify Yes o	No-			an Indian, Black,
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5-0 led wi other	ြပ္ပ	17. Father's Name (First, Middle					18	8.Mother's Mar			ile, Mai	iden Surname	3)	
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nore, MD 21215-0036  ages 1 and 2 should be filed within 72 hours after death with the Maryland and of Health and Mental Hygiene. At If Hen 27 Is marked other than "natural", or items 23a or 28a-f she other traumatic event, the Medical Examiner must be notified at once	6	19a. Informant's Name/Relation Bonnie Murphy			1695	Hoff	Lan	e F:	inks	bura	, MI	2104	48	, 24 5555,
MI nd 2 s alth a		20a. Method of Disposition	\ MTTG	20b. Place	e of Disposi					67200		20c. Location	- City or	Town, State
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Baltimore, M permit. Pages 1 and 2 Department of Health Important: If item 2		21. Signature of Fuller Service	e Licensee		P11	CCS 1	une	ton	none Boad	i alia I Was	t-m-	inster	MD	21157
		Mark Dish	or complications that cau	sed the death. Do	not enter th	ne mode of	dying, s	such as ca	rdiac or	respirator	y arres	t, shock, or he	eart	Approximate Interval
Physiciar ica		failure. List only one caus	e on each line.											Between Onset and Death
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687 ertific	<u> </u>	23b. Was decedent pregnant in past 12 months?	Diversi	th nt at time of death	2 Fe			Ectopio	pregna	псу		Month	•	Day Tea
Sox 687 leath certifu e attending:	Sician	1 Yes 2 No 9 U	Inknown g Unknow		5 Ot	ther (Speci	<i>Ty)</i>							
	غ ا	Part II. Other significant cond	litions contributing to	death but not resu	iting in the	underlying	cause g	iven in Pa	art I.					the cause of death?
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ion of Vital Records, tending Physician: The law require teath.	runeral din	27 Manner of Death	28a. Date o		8b. Time of	Injury 2	8c. Inju	ry at Work	(?	28d. Des	cribe h	ow injury occu	urred	
	me run	1 V Natural 5 Pe	ending	Day,Year)			1 \	Yes 2	No					
	1 6 E	2 Accident In	vestigation 28e. Place	of Injury - At home	e, farm, stre	et, factory,	office b	uilding, e	tc.		tion (S		nber or R	tural Route Number, City
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Divis To the Hospital or A within 24 hours after To the Funeral Direct	completely	one) 2 ✓ Medical E	xaminer:On the basis of and manner st	f examination and ated.	or investiga					at the time	, date a			
⊢ ≱ F	° 2	29b. Signature and title of cert		0		29c		e number						onth, Day, Year)
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		30. Name and address of pers			3a)	04	2-14		2400	11				
6-18		,	Assistant Medical I	AC.	11 Penn			ore, ML	2120	/ I		<del></del> -		
	Sta	11111	0 3 2008 <sup>32. Re</sup>	distrar's Signature	K A	parli	1							
	iistra			-		•								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year 10 13 2008 3:00 EDWARD JOHN MOZDZEN 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 5811 S. HAWTHORN AVE. WHISPERING KENT ROCK HALL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Months Min. Days Hours 1 ▼ M 2 □ F 002-01-6245 88 04/12/1920 NH Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1X Yes 2 □ No ROCK HALL KENT 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21661 5811 S. HAWTHORN AVE 12. Was Decedent Ever in U.S. Armed Forces?

1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐Yes 2 No Specify Specify: WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 HEALTH INSPECTOR U.S. GOVERNMENT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) WOJCICH MOZDZEN ANNA MARKOVSKA 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) BETTE MOZDZEN/DAUGHTER 3209 CHURCH HILL ROAD CENTREVILLE, MD 21617 Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) CHESAPEAKE CREMATION | 10/15/2008 | STEVENSVILLE, MD 21. Signature of Funeral Service Licensee FELLOWS HELFENBEIN & NEWNAM FUNERAL HOME PA Spren Fellers 130 SPEER ROAD CHESTERTOWN, MARYLAND 21620 Approximate Interval Between Quset and Death 23a. Jant 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final m0-Carlingma disease or condition resulting in death) Due to (or a a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 1 🗌 Yes 3 Probably 4 Unknown 24a. Was an

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

10a. State

**Funeral** 

Director

28a-f show

Director

Funeral

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Completed

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, It will click that it is not the traumatic event, It will click the second of the traumatic event, It will click the second of the traumatic event, It will click the second of the traumatic event, It will click the second of the traumatic event, It will click the second of the s

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25. Was case referred to medical examiner?

29b. Signature and title of certifier

OCT

5 Pending investigation

6 ☐ Could not be

1 Yes 2 No

27. Manner of Death

Natural Natural

2 Accident

3 Suicide

29a. Certifier

4 ☐ Homicide

Box 68760. P.0. Division of Vital Records, Hospital or Attending Physician: hours after death

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eral Director: After this certificate has been signed by the attending physician	filled in by the funeral director, page 2 should be detached for use as the burial	I Certification: To Be Completed by Physician/Medical E
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requires that the death certificate be executed Medical within 24 hou To the Fune

State Registrar

FREDERICK DELBOY MD 31. Date filed (Month, Day, Year) Registrar's Signature 14 2008

28a. Date of Injury (Month, Day, Year)

and manner stated

24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No performed? 1 ☐ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ASSISTED 1 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Scrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) カモハろそ ろり 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6602 CHURCH HILL RD. #200 CHESTERTOWN, MD 21620

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 19b,22 per fh g884 10-29-08 vt

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 3385 Reg. No. Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2310 F Miller awrence liam October 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner River nester town Hospital Lent If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1**X** M 2□ F Director 180-34-9208 65 08/20/1943 PA Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-1 show any liury or other traumatic event, the Medical Examigner must be accessed. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 No Director CHESTERTOWN MD QUEEN ANNE'S 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 218 BURCHARD SAWMILL ROAD 21620 QUEEN ANNE'S Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 2 X No 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. ģ Specify: WHITE 3 ☐ Widowed 4 ▼ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 EOUIPMENT OPERATER LABOR UNION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be မှ CHARLES R. MILLER REBECCA MCKEEVER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 42 CARDINGTON COURT CHESTER TOWN; DAUGHTER-SHELLY MARTIN 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a, Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION 10/10/2008 STEVENSVILLE, MD 21. Signature of Funeral Service Licenses FELLOWS HELFENBEIN & NEWNAM FUNERAL HOME 21651 370<del>200</del> W. CYPRESS ST. MILLINGTON, MARYLAND <del>21658</del> 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy Day in the past 12 months? Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an s certificate has be irector, page 2 s autopsy performed? Yes 20 No 1□ Yes funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes မှ 1 Inpatient 2 X ER/Outpatient 3 □ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Medical Certification: 28c. Injury at Work? After 1 Natural 5 ☐ Pending investigation 1 Tes within 24 hours after death.

To the Funeral Director: / 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I 29b. Signature and title of confier 29c. License number 29d. Dațe signed (Month, Day, Year) 100 30. Name and address of person who completed cause of death (Item 23a) (Type, Print DR. OBayomi Cheste 31. Date filed (Month, Day Year) 32. Registra Signature State

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Registrar

			1 - State Registrar		State of F	viai yiari				Death		ieniai i i	Reg. N	.20	08	3385
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21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if Item 27 is merked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, if a Marical Examination must be notified at agree.	þ	1 ☐ Never Marri 3 ☐ Widowed	ied 2 Married 4 Divorced	1 Wes 2[ If Yes, Give Year or Date	□No 19 197	155-1			Specify		, , , , , , ,		Specify		lack
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Box	th cer tendir r use	an/N	IF FEMALE: 23b. Was decedent	t pregnant	23c. If yes, outcor			□ Ectonic	c pregnan	CV.				t .	te of deliv	•
O. E	To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/I	in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	□No	4 ☐ Pregnar 9 ☐ Unknow	t at time of c		Other (			······································			Mo	กเท	Day Year
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Division of Vital Records,	or At after d Direct In by	Certification: To	4 ☐ Homicide	determined		Injury - At he etc. (Specif	ome, farm, st	reet, facto	ory, office			28f. Location City or T	(Street own, Sta	and Numb ate)	er or Rui	ral Route Number,
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	e Horie Ful	Medical	(Check only one)	2☐ Medical Exa	miner: On the basi and manner	s of examina	ation and/or i	nv <i>e</i> stigati	on, in my	opinion, de	ath occurr	red at the tim	e, dat <i>e</i> a	and place,	and due	to the cause(s)
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	83		30. Name and addr	ress of person who	completed cause of	of death (Iter	n 23a) (Type	, Print)		2 -				111101		
				JOSRIC				RAT	75 /	e AD	3 6	LIN 13	ν,	INITIA	700	nd 2073
	Sta Regist		31. Date filed (Mon	2008 Z	See 32. Heg	istrar's Signa	e de									

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Deat Physician 23:12M HME.S tober 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner Baltimore City** The Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth

Month, Day, Year)

13,1957 Birthplace (State or Foreign Country)
 WV 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday, **Funeral** Days 1 ∰ M 2 □ F 218-70-2182 51 Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov "natural", or items 23a or 28a-f sho edical Examiner must be notified at 1 ☐ Yes 2 No WV Mineral Piedmont Director 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? USA RR 6 Box 6184 by Funeral 26750 Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or ite any Injury or other traumatic event, the Medical Examiner 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify. 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Laborer New Page Paper 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James P. Noonan Jr Sara K. Jones ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Debbie L. Noonan 6 Box 6184 Keyser, WV 26726 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Ob. Place of Disposition (Name or cemetery, crematory or other place)
St. Peter's Cemetery 1 Burial 2 Cremation 3 Removal from State Westernport, MD 5 Other (Specify) 4 Donation 22. Name and Address of Facility Fredlock Funeral Home 21. Signature of Funeral Se Jones St. Piedmont, WV. 26750 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. 23a, Part 1. Enter the disease. Approximate Interval Betweer shock, or heart failure. List only Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner death certificate be executed burial-tran Due to (or as a consequence of): Box 68760, attending physician Physician/Medical the 88 IF FEMALE: nse 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death Live birth 3 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) 2 🗌 No P.O. 9 Unknown the 9 Unknown The law requires that the been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ۵ within 24 hours after death.

To the Funeral Director: After this certificate has been signed completely filled in by the funeral director, page 2 should be a No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) ၉ 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Pending investigation Injury or Attending 1 🗌 Yes 2 No 2 Accident Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (check only one) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) , MODICAL DOCTOR Ctobe

Registrar

State

nelle

600 North Wolfe St, Baltimore, MD, 21287

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

OMAIR KHWAJA YOUSUS 31. Date filed (Month, Day, Year)

OC 1

Certificate of Death

33858

sician and burial-transit Division or Vital Records, P.O. Box 68760 ed by the attending physician detached for use as the buria

3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) October 1, 2008 Katherine Louise Nicolet 5:18 p м 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Frederick Emmitsburg 400 W. Main Street | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9. Birthplace (State or Formant) | Min. | OCT 29, 1941 | Washington DC 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 1 □ M 2 💢 F 66 Yrs 223-56-9745 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If them 27 Is marked other than "natural" or home not any injury or other trainments. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Annandale Fairfax 1 ☐Yes 2X No Virginia 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 22003 USA 7734 Donnybrook Court, 108 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: white 3 ☐ Widowed 4 X Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Financial Planning Office Administrator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Marvis LaRue Manuel Louis Cooke Walters 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 400 W. Main Street, Emmitsburg, MD 21727 Kimberley Nicolet, daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 

Burial 2 □ Cremation 3 □ Removal from State Parklawn Memorial Park 10/06/2008 Rockville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Myers-Durboraw Funeral Home 21. Signature of Funeral Service Licensee 210 W. Main Street, Emmitsburg, MD 21727 ustin R. 23a. Part | Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PANCREATIC CANCER MONTHS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) 9∏Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an 1□ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient Other: 4 ☐ Nursing Home 5 ☐ Hesidence 6 ☐ Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA ဥ 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Injury 1 Matural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐Homicide 1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00062100 OCTOBER 2,2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12 1650 ORVEANS STREET, RM407 BALTIMORE, MARYLAND ZIZZI DUNG LE 32. Registrar's Signature 31. Date filed (Month, Day, Year) State OCT 0 3 Glave & Grante Registrar

**ORIGINAL** 

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3:14 P M **Physician** 15, October 2008 Woodrow Wilson North /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** St. Mary's 18228 Oakland Avenue Valley Lee If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Days Hours 17√2 M 2 □ F 78 224-52-1875 February 21, 1930 Virginia Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 1 ☐ Yes 2 No Director Maryland St. Mary's Valley Lee 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 20692 18228 Oakland Avenue Funeral 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify. White 9 3 € Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Systems Analyst Aerospace 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Richard North Annie Thompson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Joseph North / Son 21123 Camp Cosoma Road Leonardtown, MD 20650 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition October 18. 1K Burial 2 ☐ Cremation 3 ☐ Removal from State Leonardtown, Maryland Charles Memorial Gardens 4 □ Donation 5 □ Other (Specify) 2008 21. Signature of Funeral Service Lipenses 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P. P.O. Box 270 Leonardtown, MD 20650 Approximate Interval Between Onset and Death 23a. Part . Enter the disease, or complications that caused to shock, or heart failure. List only one cause on each line mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions tua to for as-Examine if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 12 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only

Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Division of Vital Records, P.O. Box 68760, attending p certificate this Director: within 24 hours a To the Funeral D

**Funeral** 

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

8

permit. Page:
Department o
Important: If
any injury or
once.

Physician /Medical

Examiner

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

Physician/Medical þ Completed Be Certification: To Medical

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

OCT 17 2008

Jennifer Schmidt, D.O.

32. Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

40900 Merchant Street Ste. 205 Leonardtown, Maryland

HUU55751

29d. Date signed (Month, Day, Year)

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Maryla				nd Mental Hy	gien	e <sub>2008</sub>	33860
			Registrar		C	ertificate c	t Death		Reg. N	0 0 0 0	
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9	or It		1 ☐ Never Married 2 ☐ Married	1 TXYes 2 □ No If Yes, Give		1 ☐ Yes 2 🔼					
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Maryland			19a. Informant's Name/Relationship (	Type. Print)	19b. M	ailing Address (Str	eet and Number	or Rural Route Numi	ber, City	or Town, State, Z	ip Code)
	1 and 2 Health tem 27 I		Deborah Womack /			8 Lake 0:		ay Bowie	, Ma	aryland	20720
<u>Sre</u>	of Healt of Healt filtem 2		20a. Method of Disposition	20b	. Place of Di cemetery,	sposition (Name of crematory or other	place)	Date	20c. I	Location - City or	Fown, State
Baltimore,			1 ☐ Burial 2 【XCremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	Tuelloral Itolli State		rematory		0-5-08	Ede	gewater,	Maryland
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Вох	atten for u	ian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time o	etal death	3 ☐Ectopic pregna 5 ☐ Other (specify				23d. Date of deli Month	Day Year
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or Vital Records,	Physician: this certific al director,	은	1 ☐ Yes 22 No	Hospital: 1 ☐ Inpatient 2	☐ ER/Outpa	tient 3 DOA	Other: 4 Nurs	ing Home 5 ☐ Res	idence	6 Other (Spec	HOSPICE
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Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral

Date of Injury (Month, Day Year) Hous Injury at Work? 1 Natural
2 Accident 5 Pending investigation M 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

29b. Signature and title of certifie

29c. License number

who completed cause of death (Item 23a) (Type, Print)

2008

21438

21/1 31. Date filed (Month, Day, Year)

OCT 0 7 State 7

egistrar's Signature

Medical Certification

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** October I, 2008 ear 11:15 A M Vivian Irene Padgett /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 1517 Upperman Road Oakland Garrett If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month Day, May 10, 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours Months Days Min 1950 1 □ M 2 X F 58 Maryland 213-56-1718 Director Usual Residence of Decedent 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits show ral", or items 23a or 28a-f shov Examiner must be notified at MD Oakland 1 ☐ Yes 2XTNo Garrett Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21550 USA 1517 Upperman Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ♣No If Yes, Give Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 72 hours after 1 □ Never Married 2 □ Married white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ Specify 3 ☐ Widowed 4X Divorced "natural", Year or Dates: Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Owner/operator Restaurant ll th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank Padgett Virginia Carder ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 104 C STreet, Mountain Lake Park, MD Venessa Stacy/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of H Important: If ite any Injury or of 1 ☐ Burial 2 M Cremation 3 ☐ Removal from State Oct 2, 2008 Country Side Crem. Davidsville, PA 4 Donation 5 Dother (Specify) 22. Name and Address of Facility
Newman Funeral Homes, P.O. Box 275 21. Signature of Funeral Service Lice see lond 179 Miller St., Grantsville, MD 21536 23a. Part1. Enter the di shock, or heart fail Immediate Cause (Final ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest are. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** a. Small cell cancer of the lung disease or condition resulting in death) 2 yrs /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Energy of the cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed and Due to (or as a consequence of): as the burial-Box 68760. physician Physician/Medical the attending nse s IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Dav 5 ☐ Other (specify) P.0. 9☐Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 XYes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform page certificate 2X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2[]\_No 10 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending Injury 1 Xaturai 5 ☐ Pending М 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To the Funeral Director: the 3 ☐ Suicide 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29b. Signature a 29c. License number title of certific 29d. Date signed (Month, Dav. Year) D30035 10-01-2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Donald R. M.D. 1533 Memorial Drive Oakland, Md Richter, 31. Date filed (Month, Day, Year)

OCT -Registrar's Signature State 2008 Registrar Marine Single

DHMH 17 Rev 1/2001

amend line 28d per me Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. aaco hlth dept 10/06/08 dlwState of Maryland / Department of Health and Mental Hygiene 2 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Edwin Pitt September 10:15 AM 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Medical Center Baltimore If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1**X** M 2□ F 24 216-15-0211 **Director** El Salvador July 10,1984 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show s 1 and 2 should be filed within 72 hours after death with the Maryla of Health and Mental Hygiene. It was 12 or 18 and 18 and 19 and 1 Anne Arundel 1 □Yes 2√2 No MD Severna Park Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 357 Valley Stream Road 21146 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☑ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 <u>S</u> 1 ∐Yes 2 TXNo Specify: White Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) College Student 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Kathleen M. Youpatoff James E. Pitt 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 357 Valley Stream Road Severna Park, MD 21146 James E. Pitt/ Father permit. Pages 1 a
Department of He
important: if item
any injury or othe 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 03, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oct. Metro Crematory, Inc. Baltimore, Maryland 2008 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 21. Signature of Funeral Service Licenses 23a. Payl 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 495 Gov. Ritchie Hwy, Severna Park, MD 21146 Immediate Cause (Final Cardiac **Physician** 40 minutes disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Failure 1 hour Respirator Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of contents Aspiration gastric 6 hours and burial-tra Due to (or as a consequence of) Box 68760 the attending physiciar certificate be Physician/Medical Guadrapalegia status post motor vehicle accident in 2006 the as IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy ŏ in the past 12 months? Month Year Day 5 Other (specify) □Yes 2□No Ö detached 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown C5-Cu subluxation status post fusion surgery, Osteomyelitis, Completed 24b. Were autopsy findings available prior to completion of cause of death? Chronic pressure ulcers, protein malnutrition, Chronic renal 24a. Was an this certificate has failure, history of trachec-esopragual fistula, Trachecistomy 2004 perform 1 □ Yes or Attending Physician: 25. Was case referred to medical examiner?

1 ✓ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 funeral 28d. Describe how injury occurred motor vehicle accident 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Certification: 28c. Injury at Work? After 5 Pending investigation 1 Natural  $\mathcal{K}^{\mathsf{M}}$ death. Feb 2,2006 1 ☐Yes 2 No 0117 2 Accident within 24 hours after death

To the Funeral Director: ,
completely filled in by the f 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Huntington 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) tate El rest D.O. RES-000 September 27, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eastern Avenue 4940 Kate Elfrey D.O. Baltimore 6 2008 egistrar's Signatu Registrar

DHMH 17 Rev 1/2001

Piease Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician /Medical City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number Examiner lace George 9. Birthplace (State or Foreign Country) Brook Haven 1949 Hississippi 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 6. Sex 1 M 2 □ F 5. Social Security Number **Funeral** Year) Days Hours Director Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hydene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show apportant: If item 27 is marked other than "natural", or items 23a or 28a-f show approach it items 20a or 28a-f show apportant. If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner must be notified at once. 1 Yes 2 □ No Funeral Director George 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes, 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Hen Fraw ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 817 AVE SE KenFrow-Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City of Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Alexandria, VA Metro Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature f Funeral Service Locusee 22. Name and Address of B cility 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Pike Forestville Ho Immediate Cause (Final disease or condition resulting in death) FAILURE **Physician** /Medical Due to (or as a consequence of): **Examiner** RD 10M Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed burial-transit Due to (or as a consequence of): physician m/ Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. ed by the a detached f 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? cate has been signed ; page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Unknown 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2 No 2 No 1 ☐ Yes To the Hospital or Attending Physician: : After this certification funeral director, I 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home Hospital: 5 Residence 6 □Other (Specify) 1 Yes 2 No 1 🗌 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Martner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

Division or Vital Records, within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

> State Registrar

7207 Hanger 31. Date filed (Month, Day, Year)
OCT 1 0 2008 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Da 2:12 P M 8 2008 October 0 Linda M. Rochon 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Howard Elkridge 8031 Nightwind Court If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 16,1942 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number 6. Sex Days Hours 1 □ M 2 🗙 F Yrs. Missouri 66 488 42 7511 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2X No Elkridge MD Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21075 8031 Nightwind Court 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2/2 No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Education Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Clifford R. Meeker Frances Patterson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8031 Nightwind Court Elkridge, MD 21075 Kenneth J. Rochon Sr./Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 10-14-2008 | Hanover, MD 4 □ Donation 5 □ Other (Specify) Ardent Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. M01044 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 MUnknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2□No autopsy performed 1□ Yes 2 **X**No 25. Was case referred to medical examiner? 26. Place of Death Check onl one

**Physician** /Medical Examiner Examiner Physician: The law requires that the death certificate be executed burial-tran and the attending physician Physician/Medical

Physician

Examiner

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notifiled at angles.

Baltimore, Maryland 21215-0036

/Medical

Director

Funeral

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Completed

Be

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certificate has been

After this

within 24 hours after death To the Funeral Director:

filled in by

completely

or Attending

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Be Completed

Medical

Division or Vital Records, P.O. Box 68760,

Other: 4 ☐ Nursing Home 5 AResidence 6 ☐ Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Injury Natural Natural

Certification: To 27. Manner of Death 2 Accident 3 ☐ Suicide

4 ☐ Homicide

5 ☐ Pending investigation 6 Could not be determined

0 9

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Yes 2 No

28d. Describe how injury occurred

Bell lane clarksille MD

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29b. Signature and title of certifie

2008

29c. License number

October 9, 2008

29d. Date signed (Month, Day, Year)

State

31. Date filed (Month, Day, Year)

00 egistrar's Signature

Registrar

			1 - State of Maryland State of Maryland	,	artment of Heartificate of Dea			ene <sub>J. No.</sub> 2008	3386	5
			Decedent's Name (First, Middle, Last)				2. Date of Death	j. 110.	3. Time of Death	_
	Physici	an	Joe Rizza				Month	Day Year		1
1	/Medic		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Loca		October	14, 2008 4c. County of Death		
	Examin	ier								
7	F		21630 Forest Park Road  5. Social Security Number 6. Sex 7. Age (In yrs. last	birthdav)	Lexington I		B. Date of Birth	St. Mary 9. Birth	place (State or Foreig	n
	Funeral Director		227-03-8504 1⊠M 2□F 92	Yrs.	Months Days Ho	ours Min.	(Month, Day, \	(ear) Cos	intry) g <b>inia</b>	
			Usual Residence of Decedent				02/08/19	916   VII	ginia	_
	/land		10a. State 10b. County 10c. City, T	own or Lo	cation				10d. Inside City Limit	3
	Mar	ţo	Maryland St. Mary's Lex	inoto	n Park				1 □ Yes 2 🗓 No	)
	r 28g	Director	10e. Street and Number	-11600	10f. Zip Code		100	g. Citizen of What Cou	intry?	
	3a o	<u>=</u>	21630 Forest Park Road		20653		Ur	nited Stat	es	
	ms 2	Funeral	11 Marital Status 12, Was Decedent Ever in U.S.	13.1	Was Decedent of Hispar If Yes, specify Cuban, M	nic Origin? (Spec	ify Yes or No-	14. Race - Amer		
9	or ite		Armed Forces?  1 □ Never Married 2 □ Married 1 □ Yes 2 □ No			pe <i>cify:</i>	ican, etc.)	Black, White		
03	al",	b	3 ☑ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:		1∐Yes 2 <b>X</b> ∏No <i>Sp</i>	респу.		Specify: Wh	rte	
21215-0036	filed within 72 hours after death with the Maryland Hygiene. wher than "natural", or items 23a or 28a-f show ant, the Medical Examir we must be rediffed at	Completed by	15. Decedent's Education (Specify only highest grade completed)	6a. Dece	dent's Usual Occupation kind of work done during	n Ia most of working	16	6b. Kind of Business/I	ndustry	
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Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Expressions translated at		, , , , ,		ng Address (Street and I					
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ore	of H fiter		20a. Method of Disposition 20b. Plac	e of Dispo etery, crer	sition (Name of natory or other place)	Da	te 20	oc. Location - City or 1	own, State	
Ĕ	Pag ment ant: I ury c		4 Donation 5 Other (Specify) Brin	sfiel	.d-Echols Ci	re 10/15	/2008	Charlotte :	Hall, MD.	
Baltimore,	permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other tr once.		21. Signature of Funeral Service Licensee	_ 22	2. Name and Address of	Facility Brin	sfield I	Funeral Ho	me, P.A.	
<b>m</b>	90 F # 9		Kyle S. Simons M01206	22	955 Hollywo	ood Road	Leonard	ltown,Mary	land 20650	
п			23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause of ach line.	Do not ent	er the mode of dying, su	uch as cardiac or	respiratory arres	st,	Approximate Interval Between	
4	Physician		Immediate Cause (Final disease or condition	CLA	ICON				Onset and Death	
	/Medical		resulting in death)  Due to (or as a consequent	ce of):						
	Examiner		Sequentially list conditions							
	ש .⊭	ne	Sequentially list conditions, if any, leading to immediate cause. Little Underlying Cause (Disease or injury that initiated events	ce of):				23		
	acute ind trans	Examine	Cause (Disease or injury that initiated events c							
Ö,	ian a	Ē	resulting in death) Last Due to (or as a consequent	ce of):						
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dical	d							
9	ertific ling p	₩	IF FEMALE:							
Box	eath certific attending p for use as f	an/	23b. Was decedent pregnant 23c. If yes, outcome of pregnance in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal de	ath 3[	Ectopic pregnancy			23d. Date of deli Month	very Day Year	
	the a	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of deal 9 ☐ Unknown	h 5	Other (specify)			World	Day 10a.	
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Records,	w requir been s should	Completed by	<u> </u>				i li fes	2 <b>2 %</b> No 3 □ Pr	DDably 4 Conknow	
ec	law lasb	륁					24a. Was an autopsy	prior to c	topsy findings availab ompletion of cause of	е
_	sician: The certificate h	등					performe 1 □ Yes 2	ed? death? No 1 ☐ Yes	2 □No	
of Vital	ician: The certificate ector, pag	Be	25. Was case referred to medical examiner?			. Place of Death				
<u></u>	Physic this c		1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER	/Outpatier	nt 3 DOA Other: 4	4 ☐ Nursing Hom	e 5 🔀 Residen	ce 6 ☐ Other (Spec	cify)	
u	ding Phy h, After thi funeral	ü	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28	b. Time o Injury	Work?	28	3d. Describe how	injury occurred		
Sio	eath. eath. or: A	cati	Accident investigation	_		2 🗆 No		_		
Division	ter d free d irect n by	Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home building, etc. (Specify)	, farm, str	eet, factory, office	28	<ol> <li>Location (Street) City or Town,</li> </ol>	eet and Number or Ru State)	ral Route Number,	
	rs al									
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	Medical	29a. Certifier  (Check only  1 Certifying Physician: To the best of my knowled Check only  2 Medical Examiner: On the basis of examination							
	the the mple	Med	one) and manner stated.		29c. License nui	mhor	200	d. Date signed (Month	Day Year)	
	<b>5</b> <u>18</u> €	_	29b. Signature and title of certifier			557S		u. Date signed (Worth	/ Day, real)	
			1 / 1000			0073	/	1413	100	
			30. Name and address of person who completed cause of death (Item 2:		*			-1	00650	
			Jennifer Schmidt, D.O. 40900 Me 31. Date filed (Month, Day, Year) 32. Registrar's Signatur		nts Lane, S	uite 205	, Leona	rdtown, MD	20650	
	Sta Registr		OCT 1 5 2008	12 :						
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DHMH 17 Rev 1/2001

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Antwan Sorrell			tate of Ma	aryland /	Depart	tment of	Health	and	Menta	l Hyg		Dec No	2	0 (	08 33
	Re	For State gistrar Decedent's Name (First, Midd	Ile Last)		Certi		Death			2.	Date of De		Vaca	3	. Time of Death
Physician Medical Examine		ANTWAN	ie,Last)	SC	RRELI						Month October				2206 hrs
7		a. Facility Name (if not instituti				4	b. City, Tov Chever		ocation of	Death			County of D		
		Prince George's Hos			e (In yrs. las	et hirthday)	if Under		If Under	24Hrs.	8. Date of E	Birth(MM/	DD/YYYY) 9	. Birth	place (State or
Funeral Director	5	Social Security Number 212-15-3110	6. Sex			Yrs.	Months	Days	Hours	Min.	MARCE	I 20	1987	Cour	MARYLAND
Director.	-	Jsual Residence of Decedent	124 M 2												0d. Inside City Limit
any	_	0a. State 10b. County	/		10c. City, T	Town or Locati	on								1 Y Yes 2 N
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nith the Maryland  5.23a or 28a-f show a		8403 HAMLIN S	TREET #	as Decedent	Ever in U.S	6. 13. Wa	a Doceden	706 t of Hisp	anic Origi	n? (Spe	cify Yes or		14. Race - / White,		an Indian, Black,
eath wi			Married A	rmed Forces?	X No	lf Y	es, specify			Puerto F	(ican, etc.)				
ifter de	의		Divorced If Yes, or Date	Give Year		1 16a. Deceder	Yes 2	<b>Y</b> -	specify:	ind of we	ork done	16b.	Specify: Kind of Busin	BLA ness/In	
nours a		15. Decedent's Education (S		est grade cor ollege (1-4 or		16a. Deceder during m	ost of work	ing life.	DO NOT	use retire	ed)	1,05			
36 in 72 l	E E	Elementary/Secondary (0-1,	2) (4	niege (1-4 or	3.)	SALE	ES						PRIVA	TE_	
15-0036 filed within 72 Hygiene. d other than	Completed	17. Father's Name (First, Midd	ile, Last)					1					n Surname)		
21215 ould be file I Mental H i marked o	8	KARL SORRELI				10h Mailin	a Address	/Stree	DOI	ROTH berorR	Y SEL.	LERS	City or Town,	, State,	Zip Code)
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland feath and Mental Hygiene. trem 27 is marked other than "natural", or items 23a or 28a-f she tranmatic event, the Medical Examiner must be notified at once	의	19a. Informant's Name/Relation DOROTHY SELI										ALE.	MARYLA	ND	20774
MD and 2 sho lealth and tem 27 is traumati	1	20a Mothed of Disposition			20b. I	Place of Dispo	sition (Nam	e of cer	netery,		Date	200	. Location - 0	City or	Town, State
ages   nt of H nt. If i		1 X Burial 2 Crema 4 Donation 5 Other	tion 3 Re	moval from S	otate	RMONY (	CEMET	ERY							ARYLAND
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural"; injury or other traumatic event, the Medical Examiner.	1	21. Signature of Funeral Serv	ice Licensee	00		22.	Name and	Address							L HOME
P. P. P. P. III.		23a. Part I. Enter the disease	-ha	VV	d the death	7 Po not enter	the mode of	ANDO	VER such as o	ROAD ardiac o	LAND r respiratory	arrest, s	MARYI hock, or hea	rt rt	Approximate Inter
Physician Medical		failure. List only one can	use on each line	e. iple Gunst											Between Onset a Death
aminer		Immediate Cause (Final dise or condition resulting in deat		o (or as a con	sequence o	of):									
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60, nte be e hysicia e buria	ian/Medical	IF FEMALE:		sc. If yes, outo	come of pre								23d. Date of Month	delive	y Day Year
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Fueral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burit	ian/I	23b. Was decedent pregnant past 12 months?	in the	Live birth Pregnant	at time of d		Fetal death Other <i>(Spe</i>		Ectop	ic pregn	ancy		World		,
Sox death c e atten I for us	ysici	1 Yes 2 No 9	Unknown 9	Unknown							220	Did tobas	course contr	ibute to	the cause of death
P.O. Es that the est that the e	y Phy	Part II. Other significant co	nditions conf	tributing to de	eath but not	resulting in the	e underlyin	g cause	given in F	Part I.	1		2 ✓ No 3		
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ital sician: is certi	8		Hospi	ital: 1 Inp	atient 2	✓ ER/Outpati	ent 3	DOA	Other <sub>4</sub>	Nurs	ing Home		sidence 6	Oth	er:
of V g Phys fter thi	6	27 Manner of Death		28a. Date of (Month D Oct 4, 200	Injury ay,Year)	28b. Time			jury at Wo		28d. Des Subject		v injury occur	red	
ion tendin eath. for: A	ja	1 Natural 5	Pending Investigation			2118 hrs			Yes 2		28f Loca	tion (Stre	et and Numb	ber or f	Rural Route Number
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the H	Medical	(Check only one) 2 Medica	I Examiner: On	the basis of	examination	n and/or invest	igation, in	ту орш	on, death	occurre	at the time	,			Month, Day, Year)
5 × 5 × 8	2	29b. Signature and title of o		0 -			2		nse numb	er		- 1	October 5		_
		tatille	KE	Sled	M	P			J.IVI.⊆.					,	
00 7	1	30. Name and address of p Patricia Aronica-F		Assistar	of death (It	em 23a) al Examine	r 111	Penn	Street,	Baltim	ore, MD	21201			
OL	Stell	31 Date filed (Month, Day,	Year)		istrar's Sign		,								
Regi	Stat stra	40700	.008 _ 8	leve	J.	A STATE OF THE PARTY OF THE PAR									

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Menth CTO CEV **Physician** 10 FM SMITH BRAXTON MARJORIE ELAINE /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** PRINCE GEORGE'S LANHAM DOCTORS HOSPITAL Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 ☐ M 2 ☐ ★F 03-14-1947 Wash.,DC 273-60-1846 61 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1 Yes 2 No Glenn Dale Director Prince George's Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20769 7108 Oakley Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∐Yes 2 [3] If Yes, Give Year or Dates: 1 ☐ Never Married 2 ₩ Married 2 -No altimore, Maryland 21215-0036 1 ☐ Yes 2 ₩ No Specify. Specify þ Black. 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Leona Braxton unk. 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Glenn Dale, Maryland 20769 7108 Oakley Road if item 27 i Leia Butler/daughter Department of Health Important: If item 27 any injury or other trong. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 10-08-2008 Riverdale, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Riverdale Pk.Crematory 22. Name and Address of Facility 21. Signature of Funeral Service License Cedar Hill FH 4111 PA Ave. Suitland, MD 20746 1ac 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician neumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): injunction Examiner ute Myo Condia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, ementia Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>ک</u> 2-X No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗆 No 2 × No 1 □Yes 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \( \text{(Specify)} \) Hospital: 1 ☐ Yes 2 No 1 Inpetient 2 ER/Outpatient 3 DOA Certification: To this 28b. Time of Injury 27. Manner of Death Date of Injury (Month, Day, Year) 28d. Describe how injury occurred funeral 28c. Injury at Work? 1 Natural 5 Pending investigation 1 □Yes 2 □ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the I 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GAILANT FOX LANE SUITE 222, Bowie MD 20715 Arora 14300 AKesh 31. Date filed (Month, Day, Year) State OCT 0 9 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar AMEND#8per INF; 10/10/08, BWW, MbCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October 5, 2008 ar **Physician** Thelma M. Sweeney 4:34P. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince George's 10E Plateau Place Greenbelt 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Days Min. Months Hours - Washington, DC 1 □ M 2√□ F 579-54-4870 66 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County ir than "natural", or items 23a or 28a-f shov 1X Yes 2 □ No Maryland Prince George's Greenbelt Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20770 United States 10E Plateau Place Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Never Married 2 ☐ Married White 1 □Yes 2 X No If Yes, Give Year or Dates: Specify. þ 3 ☐ Widowed 4 🎖 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) alth and Mental Hygiene.

27 is marked other than "n traumatic event, in the first management of the first mand management of the first management of the first management of Elementary/Secondary (0-12) College (1-4or 5+) Payroll Administrator Retail 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harry Webster Ruby Elam 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau 10E Plateau Place Greenbelt, Maryland 20770 Dean A. Jenkins -son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan Crematory 10/6/2008 Alexandria, Virginia 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service License Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Lung Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Unsease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month in the past 12 months? Day Year Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 XNo 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 □ No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 ☒No 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 📉 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

The law requires that the death certificate be executed the burial-transit and P.O. Box 68760, physician attending ph for use as the signed by the a d be detached for of Vital Records, peen this certificate has page 2 Division

death with the Maryland

72 hours after

Pages 1 and 2 should be

Baltimore, Maryland 21215-0036

28a-f show

"natural", or

Certification: To

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

Medical

28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

and manner stated. 29b. Signature and title of certifie D0064983

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number

October 6, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2101 Medical Park Drive, #200 Silver Spring, Maryland 20902 Kashif Firozvi, M.D.

State Registrar 31. Date filed (Month, Day, Year) 09 OCT 2008





	1	For State Registrar	State of Ma	aryland		artment o rtificate				giene Reg. No. 21	008	33869
Physiciar /Medica	1	1. Decedent's Name (First, Middle, Last,  Anna L. Smith	)						2. Date of Dea Month	th Day	Year	3. Time of Death 4:22 AM
Examine	•	a. Facility Name (If not institution, give		House	9	4b. City, Tow	n, or Locati			4c. Count		ery
Funeral Director		5. Social Security Number 6. Sec. 578–16–5662	7. Ag	e (In yrs. la: 93	st birthday, Yrs.	If Under 1 Y   Months   D	ear If Un ays Hou	der 24 Hrs. Irs Min.	8. Date of Birth (Month, Day Sept. 9	, Year) 1915	9. Birthi Cour Wes	place (State or Foreign ntry) Virginia
yland	-	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	ocation					1	10d. Inside City Limits
ith the Mar	מנו	Maryland Mont	gomery		Gait	hersbur				10g. Citizen of	What Cour	1 □ Yes 2 <b>x⊡x</b> No ntry?
ath with	<u>a</u>	951 Clopper Road				2	0878			USA		
ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hyglene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Exercities must be notified at	'n	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:		. 13.	Was Decedent If Yes, specify  1 □ Yes 2   ✓			ecify Yes or No- Rican, etc.)		ice - Americack, White,	etc.
ed within 72 houygiene.	nhieren	15. Decedent's Edu (Specify only highest grad	cation e completed) College (1-4or 5	+)	16a. Dece (Give life.	edent's Usual O e kind of work o DO NOT use r	ccupation one during r etired)	most of worki	ing	16b. Kind of E		
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d 2 should th and Mer 7 is mark traumatic	2 .	19a. Informant's Name/Relationship (7)  David Fiske/Neph	rpe. Print)			•			al Route Numbe	-	n, State, Zij	o Code)
les 1 and 10 des 1 d	-	20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ F				osition (Name of ematory or other			oate 10,	20c. Location	- City or To	own, State
t. Pa treer trant:	f	4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licens		For		coln Ce			08 Funeral			Maryland
permi Depai Impor any ir	N	Jan 55	Lod		5	00 Univ	ersit	y Blvd	. W., S	ilver S		a. MD 20901
Physician	i	23a. Part 1. Emer the disease, or complishock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ne cause on each lii a. <b>Metast</b> a	ne. atic ]	Lung		r ayıng, suci	n as cardiac	or respiratory ar	rest,		Interval Between Onset and Death
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e executed an and rial-transit	Examme	Sequentially list conditions, it is a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as  Due to (or as	ension	n							
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	ruysiciali/livi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal	death 3	☐ Ectopic preg ☐ Other (speci				1 1	ate of deliv	very Day Year
law requires that the speed of the signed by 2 should be detailed.	2	Part II. Other significant conditions co	ntributing to death b	ut not resul	ting in the I	underlying caus	e given in P	Part I.				the cause of death?
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s certifica lirector, p	D C	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	ent 2DE	B/Outnatie	ent 3 🗆 DOA	Othor:		h (Check only o		ther (Spec	ity) Hospice
STOTI OF tending Phy leath. tor: After this the funeral d	auon: 10	27. Manner of Death  1 ☑ Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Inju	iry 2	28b. Time Injury		Injury at Work? 1 ☐ Yes		28d. Describe I			ny nospice
al or Atte s after dec al Director ed in by th	Certification	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inj building, et	ury - At hon c. <i>(Specify)</i>	ne, farm, si	treet, factory, of	fice		28f. Location (S City or Tov	Street and Nun vn, State)	nber or Rur	ral Route Number,
e Hospit 24 hour e Funer letely fill	Medical	29a. Certifier (Check only one) 1₺ Certifying Phy 2 Medical Exam	rsician: To the best iner: On the basis of and manner st	f examinati	rledge, dea on and/or i	ath occurred at investigation, in	the time, da my opinion	te and place, , death occur	and due to the red at the time,	cause(s) and i date and place	manner as e, and due	stated. to the cause(s)
To the vithin on the complete	Me	29b. Signature and title of certifier	holes	-9			icense numb 64615			29d. Date sign		, Day, Year) <b>7,</b> 2008
, , ,		30. Name and address of person who c Genevieve Wrobles	wski, MD	135	5 Pic	card Dr	ive,	Suite	100, Rc	ckvill	e, MD	20850
State Registra		31. Date filed (Month, Day, Year)  OCT 0 9 20	32. egištr	ar's Signatu	P. A.	perter						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dav Year Month 6:35 A<sup>M</sup> October 2008 William Russell Stottlemever 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Oakland Nursing & Rehab Center Garrett 0akland | If Under 1 Year | If Under 24 Hrs. | | Months Days Hours Min. | Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 1 XM 2 ☐ F Dec. 31, 1925 Maryland 215-26-6410 82 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b County 1 ☐ Yes 2√ No MD Garrett 0akland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 21550 7812 Gorman Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 1 1 1 2 Yes 2 □ No If Yes, Give Year or Dates: WWII 14. Race - American Indian, 11, Marital Status Black, White, etc. Never Married 2☐ Married 1 ☐ Yes 2 XNo Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver State Roads Dept. 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Sarah Margaret Ours Erbie R. Stottlemeyer 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Street, Mtn. Lake Park, MD 21550 200 F Leo Stottlemeyer, Brother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cumberland Crematory 10/10/2008 Cumberland, MD 22. Name and Address of Facility David A. Burdock Funeral Home, P.A. 21 N. Second St., Oakland, MD 21550 21. Signature of Funeral Service Licenses Su Katherine Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each tine. tmmediate Cause (Final disease or condition resulting in death) EAN Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 | Yes 2 | No 3 | Probably 4 | Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes 2 🗏 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 1 Yes 2 No

Priysician /Medical Examiner

Examiner

Physician/Medical

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Certification;

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**Physician** 

/Medical

Director

Funeral

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Completed

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Examiner

**Funeral** 

Director

r than "naturel", or itema 23a or 28a-f show the Medical Examiner must be nutified at

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permit. Peges 1 and 2 should be file.
Depertment of Health and Mentel Hyg important: If item 27 is marked other any injury or other traumetic.

Baltimore, Maryland 21215-0036

anding physicien end use es the buriat-trensit signed by page 2 should be After this certificate has funeral director, nours after deeth.
nera! Director: Aft
filled in by the fur

The law requires that the death certificate be executed

Hospital or Attending Physician:

Division of Vital Records, P.O. Box 68760,

Other: 4 Nursing Home 5 Residence 6 □Other (Specify) 28d. Describe how injury occurred

27. Manner of Death 1 Natural 2 Accident 3 Suicide

4 | Homicide

5 Pending investigation 6 Could not be determined

OCT

28a. Date of Injury (Month, Day Year)

2 ER/Outpatient 3 DOA 28b. Time of Injury

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

2008

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D., 311 N. Fourth Street, Oakland, MD 21550 Kenneth Buczynski,

State Registrar

32. Registrar's Signature

DHMH 17 Rev 1/2001

within 24 hours a To the Funeral C completely filled i

State of Maryland / Department of Health and Mental Hygien = For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 6:05 A M 2008 marke? /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Coffman Nursing Home Washington Hagerstown If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 Maryland 5. Social Security Number **Funeral** 1 M 2 X F 216-09-2997 91 Yrs. **Director** October 19, 1916 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or Items 23s or 28s-1 show 1 Yes 2 No Maryland Washington Hagerstown Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21742 USA 1304 Pennsylvania Avenue Pages 1 and 2 should be filed within 72 hours after death vant of Health and Mental Hygiene.
The strain and Mental Hygiene.
The marked other then "natural", or Items 23, and other traumatic event, if a Medical Englisher manny or other traumatic event, if a Medical Englisher mann. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify ģ 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) School 12 0 Cook 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Be Lewis Thomas Clark Bernetta Beard ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JoAnn McCabe - Daughter 24 Fairground Avenue, Hagerstown, Maryland, 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State October 11. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If eny injury or once. Laurel Hill Cemetery Moscow Mills, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2008 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Eichhorn-McKenzie Funeral Home P.A. 8 East Main Street Lonaconing, MD 21539 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Priysician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to inimediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day 4☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown certificate has been signed rector, page 2 should be de Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? de⊒th? 1 ∐ Yes 2□ No 1 Yes 2 L To the Hospital or Attending Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: ၉ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Tursing Home 5 Residence 6 Other (Specify) this the funeral Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Matural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide within 24 hours a To the Funeral L filled 29a. Certifier 1 🗲 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) OCT. 9: 2001 no completed cause of death (Item 23a) (Type, Print) Struet. WITE State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 20b per fh g885 11-5-08 vt

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Deat Month Day **Physician** Oct. 5:40 P <sup>M</sup> 6, 2008 David Henry Shaffer /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3015 Hutton Road 0akland Garrett If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 X M 2 □ F 219-52-2340 58 Nov 9, Director 1949 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location r 28a-f show notified at 10a, State 10b. County 10d. Inside City Limits Director 1 ☐ Yes 2 🙀 No MD Garrett 0akland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or 3015 Hutton Road United States Funeral "natural", or items 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Affiled Folces. 1XYes 2□No If Yes, Give Year or Dates: Vietnam 1 Never Married 2X Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify Completed by 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Equipment Operator Railroad 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Boyd Shaffer 0 Emma Jane Kisner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna Shaffer, Wife 3015 Hutton Rd., Oakland. MD 21550 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages
Department of
Important: If it
any injury or c
once. W Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) <del>11</del>/09/2008 Aurora Cemetery Aurora, WV 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
David A. Burdock Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. 21 N. Second St., Oakland, MD 21550 Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à g 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed been Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy death? 1 ☐ Yes 2 ☐ No performed 2 1No Physician: director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After t 28c. Injury at Work? Hospital or Attending 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 24 hours after death Funeral Director; 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 29a. Certifier 🛮 🗸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) number Oct. 7, 2008 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Registrar

31. Date filed (Month, Day, Year)

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32. Registrar's Signature

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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Mary Jane Smith October 3, 2008 10:30 a M /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 3909 Walnut Grove Road Taneytown Carroll If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Sep 16, 1923 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 💢 F Months 193-12-7664 85 Pennsylvania Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c, City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Director Carroll Maryland Taneytown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3909 Walnut Grove Road 21787 **USA** Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: white ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Teacher Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry Homer Bock Erma M. Burk 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna C. Smith, daughter 3516 Silver Trails Dr, Ft. Collins, CO 80526 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State Trinity Lutheran Cem 10/07/2008 4 ☐ Donation 5 ☐ Other (Specify) Taneytown, MD 22. Name and Address of Facility Myers-Durboraw Funeral Home 21. Signature of Funeral Service Licenses ustin R 136 E Baltimore St, Taneytown, MD 21787 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. 23a. Part1 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Lemia **Physician** e917 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of has death? 1 ☐ Yes perform 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ✓ Yes 2 No ျှ this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: the Funeral Director: After 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 ☐ Homicide within 24 hours 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated.

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DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year) 2008

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certified

32. Regietrar's Signature

2973 Manchester

29c. License number

100051924

29d. Date signed (Month, Day, Year)

October 3,2008

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

OCT -

32. Registrar's Signature

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 2 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Tindley 11:13A Margie September 30, 2008 /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Civista Medical Center LaPLata
If Under 1 Year | If Under 24 Hrs. <u>Charles</u> Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 7. Age (In vrs. last birthday. **Funeral** Months Days Hours 1 □ M 2**X** □ F Yrs. Director 217-30-9684 73 22,1935 April Maryland Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evaning roust be notified at once. or items 23a or 28a-f show 1X Yes 2 □ No Directo Maryland Charles Waldorf 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6082 C. Thoroughbred Court Funeral 20603 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: ģ Black 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Document Preparer Imagent Inc. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ည Clarence Purnell Margie Garmon 19b. Mailing Address (Street and Number or Rural Route Number, Cify or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Isaac Tindley / Husband 6082 C. Thoroughbred Ct. Waldorf, MD 20603 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation \* 5 ☐ Other (Specify) Maryland Veterans 10/09/2008 Cheltenham, Maryland 21. Signature of Funeral Service Lice 22 Name and Address of Facility
Adams Funeral Home, PA 191 20605 Aquasco Rd. Aquasco, Maryland 20608 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Acute Asystole Probable MI disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlar-transit completely filled in by the funeral director, page 2 should be detached for use as the burlar-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy Month Day Year 5 Other (specify) P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2X No 1 ☐ Yes 2X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2X ER/Outpatient 3 □ DOA 1 🔲 Inpatient Certification: To 28a. Date of Injury (Month, Day, Year) 28b Time of 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 X Naturat 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

State Registrar

WOO KIMMD

cert

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title

Blvd Suite 200 German Town, MD 20874

29d. Date signed (Month, Day, Year)

October 8, 2008

0006669

		,	For State Registrar	State of Maryl		partment of F ertificate of			giene Reg. No.	008	33876
			Decedent's Name (First, Middle, Las	<i>t)</i>				2. Date of De	ath		3. Time of Death
-85	Physicia /Medic		Walter Williams					Month Octobei	. 3, 2	2008	1839 M
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Death		4c. C	County of Death	1
		1	Ft. Washington H	ospital			hington			ince Ge	
	Funeral Director		5. Social Security Number 6. Social Security Number 260-10-7259	MM aCE	yrs. last birthdi 1 Yrs	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Jan. 2.	th 19, Year) 5,191	7 9. Birth	iplace (State or Foreig Intry) SA
-	yland how		Usual Residence of Decedent  10a. State 10b. County	10c	. City, Town or	Location					10d. Inside City Limits
	Mar	to	DC	Ţ	Washing	ton					1⊠Yes 2 No
	r 28	lre e	10e. Street and Number			10f, Zip Code			10g. Citiza	en of What Cou	untry?
	th will	a	1800 5th St. NW			2000	1		U.S	.A.	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 ie marked other then "naturel", or Iteme 23a or 28e-f show eny injury or other treumatic event, the Medical Examinar must be motified at once.	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☒ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No lf Yes, Give Year or Dates:	in U.S. 1	3. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☑ No	dispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		4. Race - Amer Black, White Specify: B1	
ŏ	atur	ted	15. Decedent's Ed	ucation	16a. De	cedent's Usual Occur ive kind of work done	pation	ina	16b. Kin	d of Business/l	
215	hin 7	Completed	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)	lif	e. DO NOT use retire	d)	ng		. 4.	4. 2 1
2	gien er th	50	Elementary/Secondary (0-12)		Tax	i Driver				nsporta	tion
/land	uld be file Mental Hy irked oth itic event	To Be	17. Father's Name (First, Middle, Last) Walter Williams				18. Mother's Name Mattie		, Maiden S	Sumame)	
, Mary	and 2 sho alth and 1 27 ie ma er treuma		19a. Informant's Name/Relationship (7 Ronald L. Willia		19b. M 412	E. Duncan	and Number or Rura Ave., Al	al Route Numb exandri	er, City or La, V	Town, State, Z A 22301	ip Code)
nimore, Maryland 21215-0036	Pages 1 alent of He nt: if item ry or oth		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	cemetery, o	sposition (Name of crematory or other pla coln Crema	ce)	4/2008		twood,	
S. S. S. S. S. S. S. S. S. S. S. S. S. S	permit. Departmimports eny inju		21. Signature of Funeral Service Licen			22. Name and Addre	1 = 10			neral H	
	89 = 29		Paluane Ch.	Coffeeer		3401 Blade				d, MD 2	
	Physician /Medical		23a. Part1. Enter the disease, or compshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a cor	q C	enter the mode of dyi		or respiratory a	urrest,		Approximate Interval Between Onset and Peath
	Examiner	e.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	. CO	P D					-	Moute
	nd transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	. Den	تعد	tia					Moulto
8760,	cate be executed physician and the burial-transit	dical Ex	resulting in death, East	Due to (or as a cond.	nsequence or):						
9	e as t	Med	IF FEMALE:								
O. Box	that the death certific ed by the attending p detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pre 1 Live birth 2 Li 4 Pregnant at time 9 Unknown	Fetal death	3 □Ectopic pregnanc 5 □ Other (specify) _	у		2:	3d. Date of deli Month	very Day Year
Division of Vital Records, P.O	8	ρ	Part II. Other significant conditions of	ontributing to death but not	t resulting in th	e underlying cause gr	ven in Part I.			se contribute to	the cause of death?
Recol	The law requir ete has been si page 2 should I	Completed						24a. Was auto perfo		prior to death?	topsy findings available completion of cause of
ital	ician: certifice ector, p	Bec	25. Was case referred to medical				26. Place of Death				
<b>&gt;</b>	S S	70 E	examiner? 1 ☐ Yes 2 €No	Hospital: 1 Aneatient	2 ER/Outpa	itient 3 DOA	ner: 4 🗆 Nursing Ho	me 5 Res	idence 6	Other (Spec	cify)
ion o	Jing After fune	ertification; 7	27. Manner of Death 1 ■ Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Yea	ar) 28b. Tim Inju	ry Wo	ry at rk? ]Yes 2 ☐ No	28d. Describe	how injury	occurred	
Divis	ai or Attense setter deat	Certific	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (Sp.	At home, farm pecify)	street, factory, office		28f. Location ( City or To	(Street and wn, State)	d Number or Ru	ral Route Number,
114	To the Hospital or Attenwithin 24 hours effer death To the Funerel Director: completely filled in by the	Medical (	29a. Certifier (Check only one)  Certifying Ph 2 Medical Exam	ysician: To the best of my niner: On the basis of exar and manner stated.	/ knowledge, d mination and/o	eath occurred at the ti r investigation, in my (	me, date and place, opinion, death occurr	and due to the red at the time	cause(s) a date and	and manner as place, and due	stated. to the cause(s)
	To the within 2 To the comple	Σ	29b. Signature and title of certifier	black	m'M	29c. Licen:	se number		29d. Date	signed (Mont)	1, Day, Year)
	2		30. Name and address of person who Amir Mirza-Alikh	ani, 11711	Livings	ston Rd.,	Ft. WAshir	ngton,	MD 20	744	
	Sta Registr		31. Date filed (Month, Day, Year) OCT 0 9 2008	32. Registrar's S	Signature	Ī					
01	IMH 17 Pay 1/2	001	0010		1						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Year **Physician** 12:58 P M LAWRENCE WALLER OCTOBER 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S HOSPITAL CHEVERLY PRINCE GEORGE'S If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1**X** M 2 □ F 228-38-7584 74 AUGUST 29 1934 VIRGINIA Director Usual Residence of Decedent I and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show 1 ∑Yes 2 ☐ No must be notified Funeral Director MDPRINCE GEORGE'S UPPER MARLBORO 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ò 23a 11004 HERRINGTON COURT USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No ARM If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc 1 ☐ Never Married 2 Married ARMY Baltimore, Maryland 21215-0036 ò 1 ☐Yes 2 ☑ No Specify ð BLACK 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) 10th College (1-4or 5+) TRUCK DRIVER PRIVATE traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) h and Mental h VIOLA MOTLEY **JAMES** L. WALLER ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20774 19a. Informant's Name/Relationship (Type. Print) item 27 i 11004 HERRINGTON COURT UPPER MARLBORO, MARYLAND TENNIE WALLER/WIFE other 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition Date Pages 1 permit. Pages 1 Department of I Important: If ite any Injury or of 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State 10-13-2008 DANVILLE, VIRGINIA FLORAL HILLS CEME. 4 Donation 5 Other (Specify) J. B. JENKINS FUNERAL HOME 22. Name and Address of Facility 21. Signature of Funeral Service Licens 7474 LANDOVER ROAD LANDOVER, MARYLAND Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List (nly one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Physiclan: The law requires that the death certificate be executed and burial-tra resulting in death) Last Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Year Month Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributi 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes XX No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2**∑**No 1 ∐Yes XIX No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2∏xNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred I or Attending Fafter death. 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident the Director: 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Limited Medical Examiner: On the basis of examination and our investigation, in my opinion, death occurred at the time, date and place, and due to the control of th 29a. Certifier Medical (Check only estigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and marner stated 29b. Signature and title of certifier, 29d. Date signed (Month, Day, Year) OCTOBER 7, 2008

Registrar DHMH 17 Rev 1/2001

State

30. Name and address of

MOHH 31. Date filed (Month, Day,

OCT 0 9 2008

Box 68760.

P.0.

of Vital Records.

Division

· NAFICS

32. Registrar's Sign

completed cause of death (Item 23a) (Type, Print) 3001 HOSPITAL DRIVE CHEVERLY, MARYLAND 20785

			For State Registrar	State of N	/larylan		artment of F rtificate of I		d Mental Hy	giene Reg. No. 4	2008	33878
-77			1. Decedent's Name (First, Middle	, Last)					2. Date of De		Vens	3. Time of Death
€.	Physicia Medic		Turner	. N. T	Wiley				Octobe:	r 6,	2008	7:00 P.M
	Examin		4a. Facility Name (If not institution	, give street and numbe	r)		4b. City, Town, o	r Location of De	ath	4c. C	County of Death	
			Wilson Health	Care Center			Gaither				lontgomer	сy
П	Funeral		5. Social Security Number	6. Sex 7. A 1 ☑ M 2 ☐ F		ast birthday)	If Under 1 Year Months Days	If Under 24 H Hours M	in. (Month, Da	ay, Year)	Coun	ace (State or Foreign try)
ì	Director		402-10-0044	164M 201	94	Yrs.			Aug. 1	1, 19	14 0k1al	noma
	and **		Usual Residence of Decedent  10a. State 10b. County		10c. City	r, Town or Lo	cation		<del></del>		10	Od. Inside City Limits
	//anyla f sho ed at	ō	Maryland Montg	am a <b>*</b> * * * * * * * * * * * * * * * * * *	C	aither	ahura					1 <b>K</b> Yes 2□No
	the N 28a-	Director	Maryland   Montgo	omer y	G	archer	10f. Zip Code			10a. Citiza	en of What Coun	trv?
	with 3a or t be			# 308			20877				ted Stat	
	ms 2	Funeral	415 Russell Ave	12. Was Deceder	nt Ever in U.	S. 13.	Was Decedent of H	lispanic Origin?	(Specify Yes or No		4. Race - America	an Indian,
0	after ( or iter		1 □ Never Married 2 □ Marri	Armed Forces  1 Yes 2  If Yes, Give					erto Rican, etc.)		Black, White, e	etc.
ğ	ral", c	by	3 X Widowed 4 ☐ Divorced	Year or Dates	<b>:</b> :		1 □ Yes 2 🛛 No	Specify:		1 8	Specify: Wh	ite
215-0036	72 hc natu dical	Completed by	15. Decedent (Specify only highes	's Education		16a. Dece	dent's Usual Occup kind of work done o DO NOT use retired	ation during most of v	vorkina	16b. Kine	d of Business/Ind	ustry
21	ithin ner nan "	Jd I	Elementary/Secondary (0-12)	College (1-4o	r 5+)							
2	filed within 72 hours after death with the Maryland Hygiene. Hher than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	ပိ	17. Father's Name (First, Middle,	<u>4</u>		Erec	ctrical E		lame (First, Middle		erospace	
Suc	be find Head of or ever	Be						To. Mouner's in	, .			
Maryland 21	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Menth Hygene.  If item 27 is marked other than "natural", or items 23a or 28a-f show if item 27 is marked outher than "natural", or items 25a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	은	Earl 19a. Informant's Name/Relationsh	W. Wile	ey	10h Mailir	ng Address (Street	and Number or	Harriet		Turner	Codol
<u>B</u>	d 2 si th an 7 Is r traur				tor							Code)
رة ب	1 and Health em 27 other to		Carla Wiley Magr 20a. Method of Disposition	.ude1/Daugiii			ield Cour sition (Name of matory or other place		Date Pat		ation - City or To	wn. State
Baltimore,	Pages nent of I int: If its iry or o		1 ☐ Burial 2 【A Cremation		e I			i	17/2000	۸٦		71
	artme artme ortani injun		4 □ Donation 5 □ Other (S <sub>i</sub>		Met		tan Crema 2. Name and Addre					Virginia
Ba	permit. Page Department ( Important: If any injury or once,		Tille - l	OAL	لكولك		East Dee					20877
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cause	ed the death						bulg, in	Approximate
	Physician	0.4	Immediate Cause (Final	only one cause on each			/	isear				Interval Between Onset and Death
j.	/Medical		disease or condition resulting in death)	a. Due to (or a	s a consequ	VCL) CL	(ax a	1) Can				1 year
	Examiner											
	A SECTION AND A	je l	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or a	as a consequ	uence of):						
	ficate be executed g physician and ts the burial-transit	Examiner	that initiated events	C.								
o Ô	an ar rial-tı	Ě	resulting in death) Last	Due to (or a	as a consequ	ence of):				_		
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_	- D -	Ned	IF FEMALE:									
Box	leath certifi attending I for use as	an/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1 ☐ Live birth			Ectopic pregnancy	/		23	3d. Date of delive	*
	e dea he at ied fo	Sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant 9□Unknown		eath 5	Other (specify)				Month	Day Year
0	The law requires that the death certi te has been signed by the attending tage 2 should be detached for use a	Physician/M			h			on in Boot t	00- Did			
	res the	by	Part II. Other significant condition	ons contributing to death	Dut not rest	nang in the u	ndenying cause giv	en in Part i.			No 3 Prob	e cause of death?
0	w require been sign	Completed								163 2	140 3[] FIOD	ably - Olikilowii
ပ္ပ	e law nas b	nple							24a. Was	psy	prior to cor	osy findings available npletion of cause of
E		S							pert 1□ Yes	ormed? 2 No	death? 1 □ Yes	2 No
Vital Records,	sician: The law certificate has l irector, page 2 s	Be	25. Was case referred to medical examiner?	Hospital			Tout-		Death (Check only	one)		
	Physic this cal dire	은	1 Yes 2 No			ER/Outpatier		4 Nursing	g Home 5 ☐ Res			)
Ë	ding Phys h. After this c funeral dir	jon:	27. Manner of Death  1   Natural 5 □ Pending		Day Year)	28b. Time o Injury	Wor		28d. Describe	now injury	occurred	
Sic	Attend death cctor: /	icat	2 Accident investig 3 Suicide 6 Could n	not be 28e Place of i	niury = At ho	me farm str	eet, factory, office	Yes 2 □ No	28f Location	Stroot and	Number or Rura	I Pauta Numbar
Division or	after death after death Director:	Certification:	4 ☐ Homicide determ		etc. (Specif)		oot, ractory, office		City or To	wn, State)	ivaniber or nara.	rroute Number,
	spital ours neral filled		29a. Certifier 1 Certifyin	g Physician: To the bes	st of my kno	wledge, deat	h occurred at the tir	me. date and pl	ace, and due to the	cause(s) a	and manner as st	ated.
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director. After this certification ompletely filled in by the funeral director,	Medical	(Check only 2 Medical one)	Examiner: On the basis and manner:	of examina	tion and/or in	vestigation, in my o	ppinion, death o	ccurred at the time	, date and	place, and due to	the cause(s)
	ro th within ro th compl	Me	29b. Signature and title of certifier	^			29c. Licens	e number		29d. Date	signed (Month,	Day, Year)
	1		b \ ht	1) n.0	1. 1	221	D	19294	ſ	Oct	Jan 7.	200P
,	1		30. Name and address of person	who completed cause of	death (Item	23a) (Type,	Print)		C	1	1	
			// = 1	0 (0	- 1	111	0 - //	Λ	1 11	1	14 []	270

State Registrar

OCT 0 9 2008

31. Date filed (Month, Day, Year) Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

22270

Physician
/Medical
Examine

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantical must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

		Registrar	Tillicate of Death	He	g, No. 💪 U U U	00010							
		1. Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death							
Physicia		Diana Weymouth Walker		October	3, 2008	9:00 P <sup>M</sup>							
/Medic		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	occober	4c. County of Death	1							
⊏xamıı	er	Anne Arundel Medical Center	Annapolis										
		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	<u> </u>	8 Date of Birth	Anne Arui	place (State or Foreign							
uneral		104 205	Months Days Hours Min.	8. Date of Birth (Month, Day,		intry)							
irector		227-54-4090 TW XX 68 Yrs.  Usual Residence of Decedent		June 6,	1940   Vir	ginia							
>		10a. State 10b. County 10c. City, Town or Lo	ocation			10d. Inside City Limits							
sho	<u>_</u>		ocaton										
Ba-f	ctc	Maryland Anne Arundel Annape	olis			1 □ Yes 2 □ No XX							
or 2	Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Cou	ntry?							
23a	al	3736 Thomas Point Road	21403		United Sta	ates							
S E	Funeral		Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Ameri	can Indian,							
a a		1 □ Never Married 2 [Xi Married ] 1 □ Yes 2√√√No		Rican, etc.)	Black, White,	etc.							
0,5	ρ	3 ☐ Widowed 4 ☐ Divorced If Yes, Give ↑ Year or Dates:	1 □Yes 2 → No Specify:		Specify: Wh:	ite							
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ism			ing Address (Street and Number or Run	al Route Number,	City or Town, State, Zi	p Code)							
n 27 ier tu		Merrill Bradley Walker, Jr. / Husband 373	36 Thomas Point Roa	ad Annaj	oolis, Mary	land 21403							
e in the		20a. Method of Disposition 20b. Place of Dispo	osition (Name of matory or other place)	Date 2	Oc. Location - City or To	own, State							
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Copporative to the farm of the		m. 1 2 01.	47 Duke of Glouces	II M. lay	lor runera.	Home, Inc.							
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		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and Death											
sician		immediate Cause (Final disease or condition End stage Chronic Obstructive Pulmonary Disease Vear											
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he attending physiciar ed for use as the buri	an/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3	□ Ectopic pregnancy		23d. Date of deliv	very Day Year							
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 3388 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 1312 Warnick Donald Keith 8, 2008 October /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Garrett Garrett County Memorial Hospital Oakland if Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign Country) Vest Virginia 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** 1 XM 2 ☐ F Director 236-50-0727 Oct. 5, 1934 West Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Director MD 0akland Garrett 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2 sho ld be filed within 72 hours after death with : 1 and N ental Hygiene. Is marke, other than "natural", or items 23a or 2 21550 United States 420 Garrett Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ¼Yes 2 □ No If Yes, Give Year or Dates: Vietnam Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. ρ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Crew Chief U.S. Army 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be f ment of Health and Nental I Clarence Raymond Warnick Margaret Elizabeth Watkins 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2. Department of Health a Important: if item 27 is any Injury or other traionce. Mrs. Joyce Warnick, Wife 420 Garrett Road, Oakland, MD 21150 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 10/11/2008 Mt. Storm Cemetery Mt. Storm, WV 21. Signature of Funeral Service Licenses 22. Name and Address of Facility David A. Burdock Funeral Home, P.A. Katherine Sheetze 21 N. Second St., Oakland, MD 21550 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on bach line. Immediate Cause (Final Physician 3 months disease or condition resulting in death) Atherosclerotic cardiovascular disease /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Diabetes mellitus, type II vrs Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physician and s the burial-transit resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical use as attending for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Chronic obstructive pulmonary disease Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? Yes 2 No 1□ Yes or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA P the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 29a. Certifier 🖎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

24 hours after death. Hospital To the within 2

> 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. 153 Donald R. Richter, 1533 Memorial Drive Oakland, MD 21550 31. Date filed (Month, Day, Year)
> OCT 1 () 2008

29c. License numbe

D30035

29d. Date signed (Month, Day, Year) 10-08-2008

and manner stated

1+110

State Registrar 29b. Signature and title of certifier

State of Maryland / Department of Health and Mental Hygiene 🖯 🖺 🧛 33881 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 1:40 PMM 8, October 0 2008 Betty Louise Warren /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Rising Sun Cecil Calvert Manor Healthcare Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2XXF Days Yrs. 14, 1924 Maryland 83 Director 219-14-2371 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location a 23a or 28a-f show 1 Yes 2 □ No North East Cecil Maryland Directo the 10g. Citizen of What Country? 10f, Zip Code 10e Street and Number United States 21901 13 Thomas Avenue Funeral death 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black White etc. the Medical Examiner. within 72 hours after I ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 6 1 ☐ Yes 2 X No Specify: Specify: White þ 3 ♥ Widowed 4 Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 2 Elementary/Secondary (0-12) College (1-4or 5+) marked other than 7 12 Secretary Government pell 18 Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if item 27 is marked othn any injury or other traumatic event, pubs. Maryland 17. Father's Name (First, Middle, Last) Florence A. Clark Jesse O. Meekins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 13 Thomas Avenue, North East, Maryland Betty Jo Truslow / Daughter Saltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cometery, crematory or other place)
St. Mary Anne S
Cemetery 1 Deurial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) October8 North East, Maryland 21. Signature of Funeral Sprvice Licensee 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, Maryland21901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) unknown , Physician 2 ve Vova /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter the daylor of Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physicien and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, à 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performs 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 1 Yes 2 No director. 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Other: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Warsing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No after death. investigation the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide To the Hospital 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ical 29a. Certifier within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of centifier person who completed cause of death (Item 23a) (Type, Print) 3/L 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygien@ [] [] ? Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** PM 12, 2008 1458 Young, October 0 Jr. Frederick Bruce /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Garrett Garrett County Memorial Hospital 0akland Il Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** Days 1**X** M 2□F April 4, 1945 West Virginia 63 Director 235-68-2550 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State r than "natural", or items 23a or 28e-f show the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director WV Putnam Hurricane 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 25526 14 Woodclyffe Road Be Completed by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. within 72 hours after 1 X) Yes 2 □ No 1971 — If Yes, Give Year or Dates: 1974 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: White 3 Widowed 4 Divorced 1974 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 4 Keiths Kitchen's Accountant/Controller other treumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 90 Barbara Hogg Frederick Bruce Young, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 14 Woodclyffe Road, Hurricane, WV Judith Ann Young, Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 10/15/2008 1 ☐ Buriel 2 ☐ Cremation 3 🖔 Removal from State permit. Page Department c Importent: if eny injury or once. Tyler Mtn. Memorial Gardens Cross Lanes, WV <sup>¹</sup> 4 □Donation 5 □ Other (Specify) 21. Signature of Funerel Service Licensee 22. Name and Address of Facility David A. Burdock Funeral Home, P.A. 21 N. Second St. Oakland, MD 21550 Katherine Sucitive 23a. Pert1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of pach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ardiogenic Minutes **Physician** /Medical About 3 Due to (or as a consequence of): Examiner le MI Hours Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physicien and s the burial-translt Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical use as attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s this certificate 1 Tes 2 2 No : After this certifical funeral director, Be 25. Was case reterred to medical 26. Place of Death (Check only one) caminer? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No 2 ER/Outpatient 3 □ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death To the Funeral Director: / completely filled in by the f 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0061801 10-12-2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nth Fourth Street, Snik+1, Oakland, Md 21550 10 K MD 3 311 uSKI 31. Date filed (Month Day Year) State 5 2008 alua Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Year Month Physician ALSTON AM 2008 10:38 ANJAYA WILL OCTOBER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A BALTIMORE HOSPITAL HARBOR If Under 1 Year | If Under 24 Hrs. 8, Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Days **№** 2□ F 55 214-54-9602 Feb. 24, 1953 Maryland Director Usual Residence of Decedent 10h County 10c. City, Town or Location 10d. Inside City Limits 10a State 28a-f show 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Modeal Exercity and be notified at MD Baltimore Dundalk 1 ☐ Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number death with 21222 USA 110 Juniper Lane 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 ሺ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2/☐No Specify Specify: Black à 3 ☐ Widowed 4 🕅 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) U.S. Postal Service Clerk years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Willie Mack Alston Pauline Artis ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 63 Baltimore, Maryland 21203 Emilia Corpuz/ Friend item 27 i Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of Important: If its any Injury or o once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery 10/25/08 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature of Funeral Service Licenses 4210 Belair Road Baltimore, MD 21206 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) SEPSIS /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (classes of injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) physician a Box 68760, Physician/Medical attending for use as 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year 5 Other (specify) signed by the a 2 No P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. à 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown cate has been signated by page 2 should b RENAL Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an DIABETES autopsy performe 1 ☐ Yes 2 ☑ No 2 V No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death After t Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation nours after death.
neral Director: Aff 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 hor To the Fune completely fi (Check only and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MO RESOOO OCTUBER 17 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BENJAMIN MARYLAND BALTIMORE LASER SOUTH HANOVER STREET 31. Date filed (Month, Day, Year) OCT 2 4 2008 2. Registrar's Signature State Registrar

		1	1 - For amend #1 Per Phy G884 10/24/08	tment of Health and Mental I JH ificate of Death	Hygiene Reg. No. 2 11 11 21	33001
				nderson 2. Date o	f Death	3. Time of Death
	Physicia		CHARLES Nomian ANDI	Seson Octo	BEN 17 2008	08:53 AM
Wang.	/Medic Examin			4b. City, Town, or Location of Death	4c. County of Death	100
أمس	LXamiii	Ç,	JOHNS HOPKINS BAY VIEW MES BALLENOS	- BANTIMONE	N/A	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year   If Under 24 Hrs.   8 Date o	f Birth 9. Birth	nplace (State or Foreign untry)
	Director		216-40-0217 1⊠ M 2□ F 66 Yrs.	06/12/	71942 Mar	ÿľánd
	pu »	-	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Local	ation		10d. Inside City Limits
	aryla shov	5	,			1 □Yes 2 ☑ No
	the M	ect	MD Baltimore Dundalk  10e. Street and Number	10f. Zip Code	10g. Citizen of What Cou	untry?
	a or		2919 Dunmurry Road Apt. A	21222	U.S.A.	,
	eath	Funeral Director				rican Indian,
10	fter d ritem inde	Fun	1 □ Never Married 2 🕅 Married 1 □ Yes 2 🕅 No	as Decedent of Hispanic Origin? (Specify Yes o Yes, specify Cuban, Mexican, Puerto Rican, etc.	Black, White	, etc.
036	al", or	by	If Yes, Give 1	□Yes 2⊠No Specify:	Specify:	White
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nd	be filk tal H d oth even	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Mi		
yla	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Evantietr riust be rediffed at	ု	Norman M. Anderson	Catherine Doherty		
Maryland	U		(1,7,7	, Address <i>(Street and Number or Rural Route N</i> I <b>nmurry Road, Apt. A. Dund</b> a]		ap Code)
ď.	1 and 2 Health tem 27 i			y / 1	20c. Location - City or	Town, State
آور	nt of nt of it is	1	1 Burial 2 Cremation 3 Removal from State		Baltimore, Man	
Baltimore,	permit. Pages 1 and 3 Department of Health Important: If Item 27 any injury or other tr once.	i			J. Ruck, Inc.	Y Tano
Ba	permit. Pages 1 Department of H Important: If Ite any injury or ot			005 Harford Road, Baltimore,		
	_	$\vdash$	23a. Part 1. Enter the disease, or comprications that caused the death. Do not ente			Approximate
			shock, or heart failure. List only one cause on each line. Immediate Cause (Final			Interval Between Onset and Death
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4	Examiner		be to (i) as a winsequence of).	LIVER DISEASE		17 Yeahs
	-14	je	Sequentially list conditions.	-100 012		
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Вох	eath certific attending p for use as	ian/	23b. Was decedent pregnant    23c. If yes, outcome of pregnancy   1	Ectopic pregnancy	23d. Date of del Month	ivery Day Year
0	the a	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 5 ☐ 9 ☐ Unknown	Other (specify)		
σ.	that the de ned by the a detached t		Part II. Other significant conditions contributing to death but not resulting in the un-	derlying cause given in Part I. 23e.	Did tobacco use contribute to	the cause of death?
Records,	w requires that s been signed I should be det	d by			1 ☐ Yes 2 No 3 ☐ Pr	robably 4 🗆 Unknown
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Re	slcian: The law certificate has t rector, page 2 s	du			autopsy prior to death?	completion of cause of
a	n: Ti ificate or, pa		25. Was case referred to medical	1 □ Y 26. Place of Death (Check of		2 □ No
5	Physician: r this certifica ral director, p	o Be	examiner?  1  Yes 2 No	To::	Residence 6 ☐ Other (Spe	cifu)
Division of Vital	a Phy er this eral c	Ë	27. Manner of Death 28a. Date of Injury 28b. Time of		ribe how injury occurred	
Ö	ath. T. Aft	atio	1 ☑ Natural 5 ☐ Pending (Month, Day, Year) Injury 2 ☐ Accident investigation	M 1 □Yes 2 □No		
Vis	or Attending after death. Director: Afte in by the fune	ti	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, stre building, etc. (Specify)	et, factory, office 28f. Locat	ion (Street and Number or Ru or Town, State)	ural Route Number,
Ö	tal or rs after al Direction	Certification: To	3,		,	
	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate hat completely filled in by the funeral director, page		29a. Certifier (Check only (Ch			
	To the within 2 To the Complet	Medical	one) and manner stated.  29b. Signature and title of certifie)	29c. License number	29d. Date signed (Mont	h Day Year)
	5 ≥ 6 8	-	290. Signature and title or certified	RES-000	OCTOBER 17'	
9	٢				OCIOREL 11	2000
	H		30. Name and address of person who completed cause of death (Item 23a) (Type, F	AUGURE BACTIMON	E MA 2"	224
				100000 -1011.01	1 1	1
	Sta	ite	31. Date filed (Month, Day, Year)  OCT 2 4 2008  32. Registrar's Signature	E		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TITEM#23a ptT perPHYS G886,12/16/08 WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** October 20 Marcelline C. Aucremanne 2008 7:46 РΜ /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 639 Blossom Drive Rockville Montgomery 5. Social Security Number if Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, ) April 4, 9. Birthplace (State or Foreign Country) West Virginia 7. Age (In yrs. last birthday) **Funeral** Year) 1922 Months Days 1 □ M 2 🖺 F Hours Min. 235-20-4409 86 West Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Wedical Exemirer must be notified at 1 X Yes 2 ☐ No Director Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 639 Blossom Drive 20850 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 💆 No 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No If Yes Give Specify þ 3 Widowed 4 Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event. It always Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry C. Coyne Mary A. Coughlin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marcel J. Aucremanne/Husband 639 Blossom Drive, Rockville, Maryland 20850 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State October 24, Silver Spring, 1 Burial 2 □ Cremation 3 □ Removal from State Gate of Heaven 2008 4 ☐ Donation 5 ☐ Other (Specify) Maryland 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home, Rockville, Inc.
300 West Montgomery Avenue, Rockville, Maryland 20850-2805 21. Signature of Funeral Service Licensee M01544 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line.

Immediate Cause (Final Esophageal Carcinoma Approximate Interval Between Onset and Death One Year **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ALzheimer's Disease Two Years Sequentially list conditions, if any, bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner and I-trar -burial-t Due to (or as a consequence of): physician the burial Physician/Medical attending properties for use as as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ Kyphoscoliosis 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed Pernicious Anemia 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 s autopsy performed? 1 □ Yes 2 🖾 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 X Natural 1 ☐Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, To the I within 2 To the I

certificate

within 72 hours after death

Baltimore, Maryland 21215-0036

P.O. Box 68760

Alan A. Pollack, M.D., 1201 Seven Locks Road, Suite 111, Rockville, Maryland 20854 32. Registrar's Signature 00 Tar) 2 4 31. Date filed (Month, State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

mo

29c. License number D33443

29d. Date signed (Month, Day, Year)

October 21, 2008

			For State Registrar	State of Marylar	-	artment of H		-	giene Reg. No. 20	08	33886
	Physici	an	1. Decedent's Name (First, Middle, Last)  Robert A - 1	ANTAYA			<del></del>	2. Date of De Month		Year	3. Time of Death
	/Medio		4a. Facility Name (If not institution, give st 12246 Roundwood R	reet and number)	2	4b. City, Town, or			4c. County Balti	of Death	7
	Funeral Director		032-10-0012	7. Age (In yrs M 2□ F 87	. <i>last birthd</i> a <i>y)</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir	8. Date of Bir (Month, Da March	7, 1921	9. Birthpl: Count Mass	ace (State or Foreign ry) achusetts
	Maryland a-f show fied at	tor	Usual Residence of Decedent  10a. State 10b. County  Md. Baltimor		ity, Town or Lo	ocation				10	d. Inside City Limits 1 □Yes 2 ☑ No
	or 282	Funeral Director	10e. Street and Number		20	10f. Zip Code			10g. Citizen of \		ry?
	sath w	eral	12246 Roundwood	Road Unit 60 2. Was Decedent Ever in U		21093	ispanio Origina	(Specify Vac or No	14 Rec	USA ce - America	an Indian
980	ours after de ral", or item	by	11. Marital Status  1 □ Never Married 2 □ Married  3 ሺ Widowed 4 □ Divorced	Armed Forces?  1		Was Decedent of H If Yes, specify Cuba 1 □Yes 2 <b>□</b> No	Specify:	erto Rican, etc.)		ck, White, e	tc.
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, I'm Mudical Examiner must be notified at	Completed	15. Decedent's Educi (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)	16a. Dece (Give life. Execu	dent's Usual Occup kind of work done o DO NOT use retired tive	ation during most of w d)	orking	16b. Kind of Bi	usiness/Ind	ustry
Maryland 2	uld be filed Mental Hygi arked other atic event, I	To Be Co	17. Father's Name (First, Middle, Last)  Arthur Antaya				18. Mother's Na Lillian	ame (First, Middle, Marrit		ne)	
, Mar	and 2 sho ealth and n 27 is m		19a. Informant's Name/Relationship (Type Mrs. Susan Oslund/	Daughter	302	ng Address (Street Stanmore		timore,	Md. 2123	12	
Baltimore,	permit. Pages 1 and : Department of Health Important: If item 27 any injury or other tr once.		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	cemetery, crei	osition (Name of matory or other place Service Co		28-08	Towson		vn, State
Balt	permit. Departi Importi any inj		21. Signature of Funeral Service Licensee				rk Rd. I	owson, M	d. 21204	1	
	Physician /Medical		23a. Part 1. Enter the disease, or complete shock, or heart failure. List only one immediate Cause (Final disease or condition resulting in death)	ations that caused the dead cause on each line.  Due to (or as a conse	+ rcin	ter the mode of dyir	eg, such as cardi	ac or respiratory a	rrest,		Approximate Interval Between Onset and Death
	xecuted and I-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse							
68760,	ificate be executed g physician and as the burial-transit	dical	L <sub>d</sub> .								
O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23  Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown	c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3	☐ Ectopic pregnanc ☐ Other (specify) _	у			ate of delive	ry Day Year
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ital	stan: ]	Be C	25. Was case referred to nedical examiner?				26. Place of D	1 □Yes eath (Check only o		ILITES .	2 L NO
of V	ding Phystcian: The In. After this certificate his funeral director, page	2	1 Yes 2 1 No	spital: 1 Inpatient 2				Home 5 Thesi			"
Division of Vital	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certification of the funeral director, and the funeral director.	Certification:	27. Manner of Death  1	28a. Date of Injury (Month, Day, Year)	28b. Time o	M 1 🗆	yat k? Yes 2 □ No		how injury occur		
Div	To the Hospital or Attent within 24 hours after death To the Funeral Director; completely filled in by the		4 Homicide determined	28e. Place of Injury - At I building, etc. (Spec			mo, data and ala	City or To			
	To the Hospital within 24 hours To the Funeral completely filled	Medical		er: On the basis of examir and manner stated.			ppinion, death oc			and due to	the cause(s)
	¥ § ¥ 8		1 your			15					
	10		30. Name and address of person who con	BUAS MA	em 23a) (Type,	Print)	m Rel	Cockensu,	ille Me	d 210	30
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature		.,,00-	, , , ,	-	-	

Registrar DHMH 17 Rev 1/2001 31. Date filed (Month, Day, Year) OCT 2 4 2008





			1 - State Registrar  Amend State Of Maryland Department of Death  Certificate of Death	nd Mei	ntal Hyg	iene2 (	800	3388	3 7
П	Physici	an	1. Decedent's Name (First, Middle, Last)	2.	Date of Death		Year	3. Time of Dear	
	/Medic	al	HOWARD BOBLIT		Oct.	13,	2 <sup>Year</sup> 8	8:15	MM
	Examin	er	4a. Facility Name (If not institution, give street and number)  Caroline Home for Hospice  Denton, MD	Death			ity of Death aroli	10	
4	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year   If Under 24	Hrs. 8.	Date of Birth	1		ace (State or For	reian
	Director			Min.	Date of Birth (Month, Day, 06-06	-31	Balt	imore, M	îD
	P.		Usual Residence of Decedent						
	arylar show	Ä	10a. State   10b. County   10c. City, Town or Location   MD   Caroline   Greensboro				10	od. Inside City Lir 1 X Yes 2 □	
	the M	ecto			1 44	0.4	(1411 - 1 0		NO
	with a or	<b>Funeral Director</b>	10e. Street and Number 99-A Whiteleyburg Road 10f. Zip Code 21639			ug. Citizen o $\mathbb{U}SI$	f What Count ∆	ry ?	
	ns 23	era		n? (Specify	v Yes or No-		ace - America	an Indian.	
Baltimore, Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner rout by in fillied at	by	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in 95 0  13. Was Decedent of Hispanic Origin' If Yes, specify Cuban, Mexican, Professional Profe	Puerto Ric	an, etc.)		ack, White, e		
5-0	72 ho	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of	of working	- 1	16b. Kind of	Business/Ind	ustry	
2	ithin he.	ηble	Elementary/Secondary (0-12) College (1-4or 5+)	ii working					
7	led w lygiei her th		12th Wood Worker					Industr	У_
anc	i be fi	Be			irst, Middle, N Lyder	taiden Surna	ame)		
Z	should be filed within and Mental Hygiene. is marked other than aumatic event, the Mental Hygiene.	٩	19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number o.			City or Tow	n State Zin	Codo)	
S	nd 2 s alth ar 27 is r trau		Frances B. Boblit 99A Whiteleyburg			_	•	•	ł Q
ē,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra		20a. Method of Disposition 20b. Place of Disposition (Name of	Date			n - City or To		
Ë	Page nent c int: If		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Contact of State of St	0/13	/08 1	Washi	nator	n DC	
<del>=</del>	porta porta y Inju		21. Signature of Fundal Service Licensee 22. Name and Address of Facility A						me
<u> </u>	89 5 8 9		3821 - 14th St						
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as car shock, or heart failure. List only one cause on each line.	ardiac or re	spiratory arre	est,		Approximate Interval Between Onset and Death	
1	Physician		Immediate Cause (Final disease or condition resulting in death) aa.					emont	
	/Medical Examiner		Due to (or as a consequence 1):						
		er	Sequentially list conditions, if any, leading to immediate could. Enter Underlying Cause (Olsease or injury						
Ý	outed ansit	Examiner	eause. Enter Underlying Cause (Disease or injury that initiated events						
ó	e exec		resulting in death) Last Due to (or as a consequence of):						
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dical	d						
وَ ×	ertific Jing p	/Mec	IF FEMALE:			1			
. Box	eath certifii attending p for use as	ian	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)			1	ate of deliver fonth	ry Day Year	
o.	uires that the de signed by the d be detached t	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown  4 ☐ Pregnant at time of death 5 ☐ Other (specify)						
о. С.	that ned b deta		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tob	acco use co	ntribute to the	e cause of death?	,
Records,	w requires been sig should be	ed by			1, X Ye	s 2 No	3 ☐ Proba	abiy 4 🗆 Unkno	wn
000	e law re has ber je 2 sho	plet			24a. Was an		. Were autop	sy findings availa	ıble
ř	sician: The la certificate ha rector, page 2	Completed			autopsy perform 1 □ Yes 2	led?	death?	pletion of cause 2 □No	Of
Vital	slclan: certific rector,	Be (	examiner:	Death (C	heck only one				
5	Physl this c	2			5 Resider			Hospic	:e
Division of	ding Phys h. After this funeral dir	io	27. Mapner of Death 1 Natural 5 □ Pending (Month, Day, Year) 2 □ Accident investigation 28a. Date of Injury 28b. Time of Injury 4 Work? 1 □ Yes 2 □ No		. Describe how	w injury occu	irred		
18	Attencr death	fica	3 ☐ Suicide 6 ☐ Could not be 28e Place of Injury - At home farm street factory office		Location (Str.	eet and Num	ber or Rural	Route Number.	
á	al or	Certification:	4 ☐ Homicide determined building, etc. (Specify)		City or Town,			,	
	To the Hospital or Attending Physician: within 24 hours after death, To the Funeral Director. After this certifica completely filled in by the funeral director,	edical (	29a. Certifier (Check only one)  1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and property on the basis of examination and/or investigation, in my opinion, death of and manner stated.	place, and occurred a	due to the ca at the time, da	ause(s) and rate and place	manner as sta e, and due to	ated. the cause(s)	
	Voith Com	Ž	29b. Signature and title of certified 29c. License number		29	d. Date sign	ed (Month, D	ay, Year)	
			D 66270	)		10	20/	80	
	3		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		201	Tr = - 1	, 7	MD 016	0.1
	Stat		David Halverson, MD - 8221 Teal Drive, Sui  31. Date filed (Month, Day, Year) 32. Registrar's Signature	rte .	20T -	Last	ern,	MD 216	ŊΤ
	Registra		OCT 2 4 2008						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 0250 Robert Dwight Bibby 7008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Randalistown
If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. Seasons Hospice Baltimore

9. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** NOM 2□F Months W.VA Director 298-22-5712 Usual Residence of Decedent within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "natural", or items 23a or 28a-f shout te Modical Examinar must be notified at 1 ☐ Yes 2 No Director Baltimore Randallstown 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 3932 Carthage Road Funeral USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: African-American 1 □Yes 2 No Specify þ 3 ☐Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) should be filed within 7 and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Produce Conceny Loader injury or other traumatic event, 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hi Important: If item 27 Is marked oth any injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Surname) Be Bertha Bibby 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4991 Demere Court, Stone Mountain, Georgia 30083 Deborah McCoy/ Niece 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland Metro Crematory ematory 10-24-08 partitions, raryland 22. Name and Address of Facility Wile Funeral Figure 1.A. of Faito. (b. 21. Signature of Funeral Service Licensee 9200 Liberty Road, Randallstown, MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician TERMINA UNG /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if a y leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 4 Pregnant at time of death signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown this certificate has been siral director, page 2 should I Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 **N**0 2. No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2⊉No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After thi 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred HOSPICE 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the f 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide TÉ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical To th. within 2. (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier no completed cause of death (Item 23a) (Type, Print) Smith Avenue Suite 203 Bathmare MD 21209 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar most.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #5, per FH G885 11/5/08 TT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		•	For State of Maryland / Department of Health and M  State Of Maryland / Department of Health and M  Certificate of Death		giene Reg. No. 2008	33889
	Physicia		1. Decedent's Name (First, Middle, Last) Ninian Brodbeck	2. Date of Dea Month 10/23	. Day Year	3. Time of Death  2:27 A <sup>M</sup>
	/Medic Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	10/25	4c. County of Dear	th
	Funeral Director		308 Willrich Circle Unit D Forest Hill 5. Social Security Number 1 $\square$ M 2 F $\square$ 7. Age (In yrs. last birthday) If Under 1 Year   If Under 24 Hrs. Months   Days   Hours   Min.	8. Date of Birt (Month, Day 12/5/	Harford h Year) 9. Bir 1910 Ken	thplace (State or Foreign buntry) LUCKY
	D .	or	Usual Residence of Decedent  10a. State			10d. Inside City Limits 1 □ Yes 2 No
	n the N r 28a-1 notifi	irect	10e. Street and Number 10f. Zip Code		10g. Citizen of What Co	untry?
	sath wit s 23a c nust be	Funeral Director	308 Willrich Circle Unit D 21050		U.S.A.	olasa Iralian
0000	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Memlal Hygiene. I feel filen 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, it a Medical Examiner must be notified at	by	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ☑ No If Yes, specify Cuban, Mexican, Puerto If Yes, Give Year or Dates:	Rican, etc.)	Black, Whit	e, etc.
D-C   2	nin 72 ho e. In "natur Medical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	ng	16b. Kind of Business	/Industry
777	led with Hygiene her tha ht, tre	Com	2 Homemaker	/First Middle	Own Home	
an	should be fi tnd Mental H s marked ot umatic ever	To Be	17. Father's Name (First, Middle, Last) Ulysses S Grant Daniels  18. Mother's Name Lucy Pre		waiden Surianey	
, mary	es 1 and 2 shou of Health and N item 27 is ma r other trauma		19a. Informant's Name/Relationship (Type. Print) Mary Lou Carr/Daughter  19b. Mailing Address (Street and Number or Rura 308 Willrich Circle	e Unit	D, Fores	t Hill MD
HOLE	Pages 1 nent of H int: If iter iry or oth		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Chesapeake Crem. 10/24	)ate	20c. Location - City or	
раншо	permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral Service Licensee  22. Name and Address of Facility CAF  8717 Green Pastu	FA/Ste	phen D Lo	hrmann P.A
			23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac cannot shock, or heart failure. List only one cause on each line.			Approximate Interval Between Qnset and Death
40	hysician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):	re		245
pul <sup>15</sup>	Examiner	<u>.</u>	Sequentially list conditions b.			
S	outed and ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events			
00/00	rtificate be executed ng physician and as the burial-transit	edical Exa	resulting in death) Last  Due to (or as a consequence of):			
	th certificat tending phy r use as the		IF FEMALE: 23b. Was decedent pregnant in the part 12 months?  1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of de	
5	the dea y the at iched fo	Physician/M	in the past 12 months?  1 ☐ Yes 2 ☐ No 9 ☐ Unknown		Month	Day Year
cords, r	quires that an signed b uld be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	obacco use contribute to ves 2 No 3 □ P	o the cause of death?
Leco	of the <b>Hospital or Attending Physician:</b> The law requires that the death cert within 24 hours after death.  To the Luneral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use a	Completed	Ostegarosis	24a. Was autop perfor 1 □ Yes	esy prior to rmed? death?	utopsy findings available completion of cause of
N E	sician: s certific lirector,	Be	25. Was case referred to medical examiner?  1 Yes 2 No   26. Place of Death Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hotel		ne) dence 6 □Other (Spe	
vision or	nding Phy ath. r: After this ie funeral d	ation: To		<del> </del>	now injury occurred	icity)
N/S	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S City or Tow	Street and Number or R vn, State)	ural Route Number,
	e Hospi 24 hou e Funer letely fil	edical	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurr and manner stated.			
	To th Withir To th сопр	Me	29b. Signature and title of certifier 29c. License number		29d. Date signed (Mont	th, Day, Year)
	1 .		30. Name and address of person who completed cathse of death (Item 23a) (Type, Print)	/	123/00	
	V		Gillian Adams			
	Sta Registr		31. Date filed (Month, Day, Year)  32. Registrar's Signature			

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Bernard C. Brzozowski, Sr. 10-21-2008 6:40 Α /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Balto. 9901 Fox Hill Drive Perry Hall If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 86 1 X M 2 □ F 7-21-1922 Balto. Md. Director 213-18-3255 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f show event, the Medical Exercitors is ust be notified at 10a State 10b. County 1 ☐ Yes 2 X No Director Balto. Perry Hall Md. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 9901 Fox Hill Drive 21128 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 [Yes 2 ☐ If Yes, Give Year or Dates: 2 No 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 🐼 No Specify: White þ Specify: 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 27 is marked other than "n traumatic event Elementary/Secondary (0-12) College (1-4or 5+) Local #333 ILA LongShoreman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be innent of Health and Mental Anna Barbara Modrak ပ Joseph Brzozowski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Nottingham, Md. 21236 DTR. 9522 Oakbranch Way permit. Pages 1 and Department of Health Important: If item 27 any Injury or other troonce. Michele Brzozowski Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10-25-2008 Balto, City Most Holy Redeemer 22. Name and Address of Facility Funeral Service Schimunek Funeral Home 9705 Belair Rd. Nottingham, Md. 21236 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician erebral disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner for as a consequence of): VEN Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner sician and burial-transit Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) signed by the a d be detached for P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 2 🔁 No 1 ☐ Yes 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an has autopsy certificate Hupencholester
25. Wa se referred to medical examiner? 1 □Yes 2 No of Vital funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Division Hospital or Attending 1 Natural 2 ☐ Accident 5 Pending death 1 ☐ Yes 2 ☐ No investigation within 24 hours a er death

To the Funeral Director:
completely filled in by the Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

I Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check o one) and manner stated. 29d. Date signed (Month, Day, Year) title of certifier 29b. Signature ar 0-24-2009 dress of person who completed cause of death (Item 23a) (Type, Print) 30 Name an 10 owson 505 Osler 100 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 29c per dvr g884 10-24-08 vt
State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar	State of Mar	-	•	ficate of L		ivieritai i iy	Reg. No	0000	33891
	Physici	an	1. Decedent's Name (First, Middle, Last)  MARY ELIZAB	ETH BLE	2050F	_			2. Date of De Month	eath Day	y Year 2008	3. Time of Death 9.30 P M
	/Medic		4a. Facility Name (If not institution, give s	street and number)		41:		Location of Deat	h		County of Death	
***	Summer		5. Social Security Number 6. Sex		In yrs. last birt		Under 1 Year	IN STER	<u>,                                     </u>	rth	CARRO	place (State or Foreign
	Funeral Director		218-40-4212	М 2 🔀 F 6	_ `	rs. M	onths Days	Hours Min.	8. Date of Bi (Month, D	ay, Year) 941	MD	ntry)
	yland		Usual Residence of Decedent  10a. State 10b. County	10	0c. City, Town	or Location	on					Od. Inside City Limits
	he Mar 28a-f sl	ector	MD Carroll		Mt. A	iry	101 71 0			10.00		1 □ Yes <del>X</del> No
	3a or 3	<b>Funeral Director</b>	10e. Street and Number 2441 Braddock Rd.				10f. Zip Code 217	771			izen of What Coul .ted Stat	•
	r death	uner	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S.	13. Was	Decedent of H	ispanic Origin? (5 n, Mexican, Puer	Specify Yes or Noto Rican, etc.)	0-	14. Race - Ameri Black, White,	
980	be filed within 72 hours after death with the Maryland nat Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Middel Evilor in a to use to motify a	þ	1 ☐ Never Married 2€ Married 3 ☐ Widowed 4 ☐ Divorced	1 □Yes 2 No If Yes, Give Year or Dates:		1 🗆	Yes 2√∑No	Specify:			Specify: [	Mhite
Baltimore, Maryland 21215-0036	"natur	Completed	15. Decedent's Educ (Specify only highest grade	cation e co <i>mpleted)</i>	16a.	Decedent	t's Usual Occup	ation during most of wo	rking	16b. K	ind of Business/In	dustry
212	e filed within al Hygiene. I other than " vent, the two	Somp	Elementary/Secondary (0-12)  12th	College (1-4or 5+)		erk				Stat	e of MD	
and	be file ntal Hy ed oth	Be	17. Father's Name (First, Middle, Last)					18. Mother's Nar		, Maiden	Surname)	
aryk	should be ind Menta marked imatic ev	ဥ	Guy Edward Grimes  19a. Informant's Name/Relationship (Ty)	pe. Print)	19b.	Mailing A	ddress (Street a		Inknown ural Route Numb	per, City o	or Town, State, Zij	o Code)
Š,	and 2 lealth a m 27 ls		Michael Bledsoe	Jr. (son	) 410	)7_Se	quoia D	r. Westn	inster,	_MD_	21157	
nore	Pages 1 nent of H ant: If ite ury or ot		20a. Method of Disposition  1 X Burial 2 ☐ Cremation 3 ☐ R  4 ☐ Donation 5 ☐ Other (Specify)	ternoval from State			on (Name of ory or other plac Iem Park	e) 10/2	Date /		cation - City or To	*
altin	permit. Pages 1 and 2 should I Department of Health and Men Important: If item 27 Is marke any injury or other traumatic o		21. Signatur	111	Barc V.	22. Na	ame and Addres	ss of Facility				
	20 E 20		25a. Part 1. Enter the disease, or compli	inations that caused th	a death. Do n	1212	y w. oll	en runer 1 1BERT	Rd. Wi	nfie	l Cremato <del>ld, MD</del> 2	170/
II.	Physician	E 114	shock, or heart failure. List only or Immediate Cause (Final disease or condition	ne cause on each line.			NARY			arrest,		Interval Between Onset and Death
-	/Medical Examiner		resulting in death)  Due to (or as a consequence of):  PERFORATED VISCUS  1 death									
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a c			) VIO	eas.				1 day
A	ecuted and transit	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a c								
68760,	rificate be executed go physician and as the burial-transit	calE		d.	onsequence d	,,,.						
		/Medi	IF FEMALE:	120 If was autoams of								
. Box	Physician; The law requires that the death cer this certificate has been signed by the attendir ral director, page 2 should be detached for use	Physician/Medical	23b. Was decedent pregnant in the past 12 months?  1 \( \subseteq Yes \) 2 \( \subseteq No \)	3c. If yes, outcome of 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tir	Fetal death		ctopic pregnancy ther (specify)	У			23d. Date of deliv Month	ery Day Year
P.O.	that the dened by the a	Phys	9 ☐ Unknown  Part II. Other significant conditions con	9 Unknown	ot reculting in	the under	rhing couce give	on in Bort I	23e Did	tobacco	use contribute to t	he cause of death?
rds,	quires t en signe uld be c	ed by		This dailing to dodd to but I		tho direct	my mg oddoo grve					bably 4 Unknown
eco	e law requir has been si e 2 should l	Completed							24a. Was	psy	prior to co	opsy findings available ompletion of cause of
la F	in; The ificate I		25. Was case referred to medical						1 □Yes		death? 1 ☐ Yes	2 No
Ž	hysicia his cerl	To Be	examiner?	lospital:	2 🔲 ER/Out	tpatient 3	3 □ DOA Othe		ath <i>(Che</i> ck o <i>nly</i> Home 5 ☐ Res		6  ☐ Other (Speci	fy)
o uo	ding P h. After t funera	tion:	27. Manner of Death  Natural 5 ☐ Pending  2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Y	<i>(ear)</i> 28b. T	njury	28c. Injury Work	y at	28d. Describe	how inju	ry occurred	
Division of Vital Records,	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification: To	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (	I - At home, far (Specify)	m, street,			28f. Location City or To	(Street ar	nd Number or Run	al Route Number,
Ω	spital o	al Cer	29a. Certifier 1 Certifying Phys	sician: To the best of r	mv knowledge	. death oc	curred at the tir	ne, date and plac	e, and due to the	e cause(s	s) and manner as	stated.
	the Ho	edical	(Check only 2 Medical Examination)	ner: On the basis of ex and manner stated	xamination and	d/or invest	tigation, in my o	pinion, death occ	urred at the time	, date an	d place, and due t	o the cause(s)
	To with	Ž	29b. Signature and title of certifier	<del>;</del>			29c. License		•		te signed (Month,	
	10		30. Name and address of person who co	mpleted cause of deat	th (Item 23a) (	Type, Prin	it)	2010				2008 R MD
	Sta	to-	Sarah Kentz, 31. Date filed (Month, Day, Year)	32. Registrar's	PROLL Signature	Hos	SPITAL	CENT	ER, W	EST	MINSTE	K MD
Н	Sta Registr		OCT 2 4 201	08	· M	Page	28					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 22, Physician 2:50 a M Dorothy Bennett October 2008 L . /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Edenwald Baltimore Towson | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Sept 9, 5. Social Security Numbe Birthplace (State or Foreign Country) (In vrs. last birthday **Funeral** Year) 1912 1 □ M 2 ☑ F 216-03-6363 96 Maryland Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or items 23a or 28a-f show MD Baltimore 1 ☐ Yes 2 ☐ No Department of Health and Mental Hygiene. Important: If Item 23a or 28a-f shimportant: If Item 27 is marked other than "natural", or Items 23a or 28a-f shany injury or other traumatic event, The Madical Eventine russ to mother Towson Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 800 Southerly Road 21286 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No ρ Specify. White 3 XWidowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Registered Nurse 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Nursing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Herbert Τ. Mary ပ Thomas Dora 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn B. Goldsteen-daughter 2020 Brighton Dam Rd., Brookeville, MD 20833 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hilltop Srv Corp 10/23/08 Towson, MD 4 Donation 5 DOther (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service Licensee William Dau 1050 York Rd., Towson, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a con Examiner Due to (or as a consequence of): attending physician Hospital or Attending Physician: The law requires that the death certificate be each hours after death.

Funeral Director: After this certificate has been signed by the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Day 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 🗌 Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 2 1 □ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Man of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 △ Natural 2 ☐ Accident 5 Pending investigation 1 🗀 Yes filled in by the 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier one) and manner stated. the within To the 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 31. Date filed (Month, Day State

DHMH 17 Rev 1/2001

Registrar

			For State Registrar	State of Ma	ryiand		rtment of F rtificate of I			giene Reg. No.2	08	33393		
H	Dhysisia		Decedent's Name (First, Middle, Last						2. Date of Dea	ath	Year	3. Time of Death		
	Physicia /Medic		Carrie P		drett		41. Oh. T.	- Landing of Daniel		ER E1,		10:00FM		
	Examin	er	4a. Facility Name (If not institution, give	Medical	Cent	er	4b. City, Town, or	Location of Death		4c. County		imore		
ı	Funeral Director		210 01 0000	ex 7. Age	(In yrs. las	t birthday) 95 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da Jan 24,	1913	9. Birthp Cour Mary	olace (State or Foreign htry) Land		
	land ow		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limit											
	a-fsh	ctor	MD Baltin	nore	Towsoi	٦					1 □Yes 2X No			
	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ent, the Medical Evan for must be motified at	al Director	10e. Street and Number 800–A Southerly	Rd., Apt 5	533		10f. Zip Code 21 28	16		10g. Citizen of What Country? U.S.A.				
J036		d by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ※ Widowed 4 ☐ Divorced	ver in U.S.		Was Decedent of H fYes, specify Cuba □Yes 2 XNo	Specify:	pecify Yes or No- o Rican, etc.)	Specify: White					
12-	n 72 h "natu	lete	15. Decedent's Ed (Specify only highest gra	ucation de completed)		16a. Deced (Give life. I	lent's Usual Occup kind of work done o OO NOT use retired	ation during most of wor f)	king	16b. Kind of Business/Industry				
a)	d within giene. ir than	To Be Completed	Elementary/Secondary (0-12)	College (1-4or 5+	-)	Hor	nemaker	,		Own home				
	be filed within 72 ho Ital Hygiene. d other than "natu event, the Medical		17. Father's Name (First, Middle, Last)	D. • •	. •			18. Mother's Nan				•		
	12 should be f h and Mental I 7 is marked of traumatic eve		William  19a. Informant's Name/Relationship (	Phil	<del>- · ·</del>	19h Mailir	g Address (Street	Marga and Number or Bu			hank]			
	s 1 and 2 should F Health and Mer tem 27 is marke other traumatic		C. Philipp Brunds				7 Chateau			-		0000)		
	permit. Pages 1 a Department of He Important: If item any Injury or othe		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	<i>(</i> )	Dula	e of Dispo etery, cren aney	sition <i>(Name of</i> natory or other plac Jalley	<sup>re)</sup> 10/	Date 25/08	20c. Location - Timon	-	•		
	permit. Departimport any Inj		21. Signature of Funeral Service Licen	₩illiam	G. Da	au	. Name and Addre	Nu	ck Towso wson, MD	n Funer 21204	al Ho	ome, Inc.		
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition  ASPIRATION FINEUMONIA									Approximate Interval Between Onset and Death DAYS		
			resulting in death)		Due to (or as a consequence of): IYELOPROLIFERATIVE DISORDER							YEARS		
7	sit sit	iner	sequentially list so fundancy, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	Due to (or as a consequence of):									
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O. Box 68	attendin for use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2▼No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 24 ☐ Pregnant at 9 ☐ Unknown	2 ☐ Fetal de	eath 3	] Ectopic pregnanc ] Other <i>(specify)</i>	у			te of delive	ery Day Year		
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r		Completed							24a. Was autop perfo 1 □ Yes	rmed?	Were auto prior to co death? 1 ∐Yes	psy findings available mpletion of cause of 2		
Vital		Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:			• 3 🗆 DOA Othe	or.	th (Check only o					
on or		tion: Tc	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injur (Month, Day,	1 trainpatient 2 EH/Outpatient 3 DOA 4 Nursing Home					e 5 ☐ Residence 6 ☐ Other (Specify)  Bd. Describe how injury occurred				
DIVISION		Certification: To	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	The second second	ry - At home (Specify)	e, farm, str			Gireet and Number or Rural Route Number, nn, State)					
		Medical (												
	Voithi Comp	ž	29b. Signature and title of certifier				29c. Licens			29d. Date signed	d (Month,	Day, Year)		
			· Ulako,	my			D256	386		Octobe	52	1,200		
	10		30. Name and address of person who	(	,	, , , , ,	-	rowson.	MARYLA	ND 212	1714			
	Sta		31. Date filed (Month, Day, Year)	32. Registra			orry de V has	wermilly	restable land	11 7 Ad	S. T.			
	Registr	ar	OCT 2.4 21	108		An	CAN I							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year Gladys E. Colbert 60 5 AM 10 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FRANKLIN SQUARE HOSPITAL Rosedale Baltimore center | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 06/11/2/1915 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕱 F 93 213-10-2551 Maryland Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mertial Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Event in a 1 by notified at 1 ☐ Yes 2 X No Director Maryland Baltimore Parkville 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 8800 Walther Blvd Apt. 1010 21234 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 X No Specify à Specify. White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Factory Worker Paper Manufacture 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Russell Colbert Celia Marie Eckhardt 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Helen Brown - Sister 8800 Walther Blvd Apt.1010 Parkville, MD 21234 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Moreland Memorial Park 10/27/2008 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility 5305 Harford Road Leonard J. Ruck, Inc. Baltimore, MD 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 3day Sepsis disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Ulmonani Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Deep Vein physician and s the burial-trans the Hospital or Attending Physician: The law requires that the death certificate be executive that Ahour stafer death.

The Law and a stafer death.

The Funeral Director: After this certificate has been signed by the attending physician and mpletely filled in by the funeral director, page 2 should be detached for use as the burial-tra Due to (or as a consequence of) Box 68760. Physician/Medical If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) P.O. ☐Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 → No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 □ Yes 2 ♣ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 24 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause death (Item 23a) (Type, Print)

State Registrar

H

13 (NH 31. Date filed (Month, Day, Year)

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Sauare

Baltimore

21237

9000 FRANKLIN

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-07864 State of Maryland / Department of Health and Mental Hygiene 2008 33895 Daequan Carrothers Certificate of Death 1- For State Reg. No 3. Time of Death Registrar 2. Date of Death Decedent's Name (First, Middle,Last) Month Day October 19, 2008 Physician/ 0746 hrs Media 'Examiner eglan 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Baltimore Johns Hopkins Hospital 8. Date of Birth(MM/DD/YYYY) g. Birthplace (State or If Under 24Hrs. 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number Foreign **Funeral** Min. Hours Country) Director 1 X M 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Yes 2 No 10g. Citizen of What Country hours after death with the Maryland Director 10f. Zip Code 10e. Street and Number 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No 12. Was Decedent Ever in U.S. Funeral 11. Marital Status White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces 1 X Never Married 2 Married 2 X No Yes è Yes 2 X No specify: If Yes, Give Year Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done 16b, Kind of Business/Industry \$ 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) vermit Pages I and 2 should be filed within 72 hou epartment of Health and Mental Hygiene. portant: If item 27 is marked "" Completed College (1-4 or 5+ Elementary Secondary (0-12) 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) (mother 8 to 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition 10/25/200 ematory or other place) Cremation 3 1 X Burial 2 M permit Page Department o Important: Donation 5 Other Specify: 22. Name and Address of Facility
Joseph Rus
2222 W. North 21. Signature of Funeral Service Licenses H e disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval . an I Enter me disease, or complication failure. List only one cause on each line Between Onset and Physician Death 1edica Sudden unexplained death in infancy Immediate Cause (Final disease **A**aminer Due to (or as a consequence of) or condition resulting in death) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit 23a,27,28a-f, permE, g88/ 1/2//09 Physician/Medical AMENDED XUNPENDED burial 23d. Date of delivery The law requires that the death certificate be Box 68760, 23c. If yes, outcome of pregnancy attending phys for use as the bu Year Day 23b. Was decedent pregnant in the Ectopic pregnancy Fetal death past 12 months? Pregnant at time of death 5 Other (Specify 1 Yes 2 No 9 Unknown signed by the atte g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. Yes 2 ✔ No 3 Probably 4 Unknown þ 24b. Were autopsy findings available Completed 24a. Was an icate has been si page 2 should b prior to completion of cause of autopsy death? performed? certificate has ✓ Yes 2 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medical To the Hospital or Attending Physician: director, Division of Vital Be Other<sub>4</sub> Nursing Home 5 Residence 6 examiner? Hospital: 1 Inpatient 2 V ER/Outpatient 3 DOA ۵ 1 ✔ Yes No After this 28d. Describe how injury occurred 28c. Injury at Work 28b. Time of Injury funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Certification: Yes 2 X No within 24 hours after death.

To the Funeral Director: A completely filled in by the fun Natura Pending filled in by the f 10/19/08 Fd 6:3<u>0</u> anh 28f. Location (Street and Number or Rural Route Number, City or Town, State) 806 N. Curley St Baltimore, MD Fd 2 Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 6 X Could not be basement of rowhouse 3 Suicide determined (Specify) Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie October 20, 2008 O.C.M.E.

State Registrar

2008 OCME

Assistant Medical Examiner

32. Registrar's Signatu

30. Name and address of person who completed cause of death (Item 23a)

Melissa Brassell, MD

31. Date filed (Month, Day, Year)

**ORIGINAL** 

111 Penn Street, Baltimore, MD 21201

Physician
/Medical
Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any liujury or other traumatic event, Its Macital Evantina in set be natified at anones. Once.

Baltimore, Maryland 21215-0036

Physician

Division of Vital Records, P.O. Box 68760,

Examiner	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	
01	

	1 - State Registrar					tificate of	Death		Reg. No.				
Month Day Year										3. Time of Death			
al			Anne Co		r			•	Oct.	22	2008 Year	0710a M	
er	4a. Facility Name (If I		4b. City, Town, o		of Death		4	c. County of Deatl	h				
	Gilchr 5. Social Security Nu	st birthday)	TOWSO		24 Hrs. I	8 Date of	Rirth	Balti	MOTE hplace (State or Foreign				
	216-32-6		6. Sex 1 ☐ M 2 🔀 F	71	Yrs.	Months Days	Hours	Min.	8. Date of (Month, Apri	Day, Yea 1 17	,1937	MD	
	Usual Residence of D	Decedent							21011		, 1 2 3 7	FID	
_		10b. County	a+		Town or Loc Berli							10d. Inside City Limits	
Scto	MD Worcester E											1 ∐Yes 2√∑No	
ä	10e. Street and Numb			10f. Zip Code				10g. Citizen of What Country?					
eral		Deauc	12 14	2181 as Decedent of F		isin? (Cn	noify Von or	USA es or No- 14. Race - American Indian,					
핊	11. Marital Status 1 □ Never Marries	d 2∏ Marı	Armed Fo		lf lf	Yes, specify Cuba	an, Mexicar	n, Puerto	Rican, etc.)	140-	Black, White		
ğ	3 ☐ Widowed 4	ve ates:	1 □Yes 2 ▼No Specify:						Specify: White				
eted	(Specifi	15. Deceden	t's Education st grade completed)		16a. Decede	ent's Usual Occup	ation	t of warki	16b.	16b. Kind of Business/Industry			
Completed by Funeral Director	Elementary/Second		-4or 5+)	(Give kind of work done during most of working life. DO NOT use retired)  Agent  Insur						Tnaumon			
	12th 17. Father's Name (F	Firet Middle	l act)		A	gent	18 Mothe	ar'e Nama	(First Mide		Insuran en Surname)	<del></del>	
Be			ncis Cor	ninger					•		Kerriq	an	
မ	19a. Informant's Nan			Pringer		Address (Street					or Town, State, Z		
			/daught	er								e MD 21075	
	20a. Method of Dispo	sition		20b. Pla	ace of Dispos	ition (Name of atory or other place	i		ate	20c.	Location - City or	Town, State	
	1 ∐ Burial 2 <b>X 1</b> 4 ☐ Donation 5		3 ☐ Removal from pecify)			Ćremat	ory	10/	23/08	B .	altimor	e MD	
	21. Signature of Fun	eral Service	Licensee	42	22.	Name and Addre	ss of Facilit	y 30	0 Mac	e A	ve. Bal	to. MD	
	Connelly Funeral Home of Essex 21221												
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause on each line.  Approximate Interval Between Open and Post a											Approximate Interval Between Onset and Death	
	Immediate Cause (F disease or condition resulting in death)		a	056	ASTON	NA				jean			
	Due to (or as a consequence of):											9	
je	Sequentially list cond if any, leading to imm	ditions, rediate	b. Due to	or as a conseque	ence of):								
Examiner	cause. Enter Underly Cause (Disease or in that initiated events	ying ijury	c.										
Ë	resulting in death) La	ıst	Due to	Due to (or as a consequence of):									
Medical	d												
_	IF FEMALE:		23c If yes out	come of pregnan	CV			-	`\				
cian	23b. Was decedent pregnant in the past 12 months?  1 □ Live birth 2 □ Fetal dea					h 3					23d. Date of delivery  Month Day Ye		
ysi	1 □Yes 2 € 1 9 □ Unknown	uii 5	5 Gottlet (specify)										
Completed by Physician	Part II. Other signific	ant condition	ons contributing to de	eath but not result	ting in the und	lerlying cause give	en in Part I		d tobacco use contribute to the cause of death?				
ed D								1[	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown				
blet					as an itopsy								
ě						pe 1 □ Ye	2 No						
Re	25. Was case referre examiner?	d to medical	-				26. Place	of Death	(Check onl				
	1∐Yes 227N	o		npatient 2 🗆 E			4 LI NU	rsing Hor	me 5□Re	esidence	6 ☐Other (Spec	sity) Hispace	
<u>:</u>	27. Manner of Death 1 Natural	5 Pendin	9	of Injury h, Day, Year)	28b. Time of Injury	28c. Injur Worl	?	1	28d. Describ	e how inj	ury occurred	4	
icat	2 Accident investigation M 1 Yes 2 No												
er	3 Suicide determined determined determined determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)												
Medical Certification: To	29a. Certifier 1	Certifyin	ng Physician: To the	hysician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
edic	(Check only 2 one)	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s										to the cause(s)	
29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day  29d. Date signed (Month, Day  25d. Saltz. M. 1. 2120)													
								tober 2	1, 2008				
	30. Name and address	of person	who completed caus	e of death (Item	23a) (Type, P	rint) /	06	6	1 Pot	or W	1121	يخ اح	
			11/1/20										
	31. Date filed (Month)	Day Year		egistrar's Signatu	/ /V	More	137		EUG:		14 2/ 6		

Stat Registra

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			For State Registrar	State of Maryland	d / Depa <i>Cert</i>	rtment of <i>ificate of</i>	Health and I Death		giene 20 (	18 33897
	Physicia	an	1. Decedent's Name (First, Middle, Last)	Raquel	Cha	ffmo	n	2. Date of Dea Month	Day Ye	3. Time of Death
	/Medic Examin	al	4a. Facility Name (If not institution, give st			4b. City, Town,	or Location of Death		4c. County of I	
			The Johns Hopkins Hos  5. Social Security Number 6. Sex	spital 7. Age (In yrs. I	ast birthday)	Baltimor		. 8. Date of Birth	n 9.	Birthplace (State or Foreign Country)
	Funeral Director		212-83-8482	M 2,7 F	Yrs.	Months Day 14		(Month, Day August		aryland
and	»		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Loc	ation				10d. Inside City Limits
e Mary	a-f sh ified a	Director	MD Baltimore	د	Lai	nsdowne				1 🗆 Yes 2 No
should be filed within 72 hours after death with the Maryland	nt of Health and Mental Hygiene. If Item 27 Is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		10e. Street and Number 2362 Research Ave.			10f. Zip-Code 212	227	1	10g. Citizen of Wha USA	t Country?
r death	tems 2	Funeral	11. Marital Status	Was Decedent Ever in U.s Armed Forces?	S. 13. V	Vas Decedent of Yes, specify Cu	Hispanic Origin? (S ban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - A Black, V	American Indian, Vhite, etc.
urs afte	al", or i	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1	☐ Yes 2. N	Specify:		Specify:	White
72 ho	"natur	Completed	15. Decedent's Educ (Specify only highest grade	completed)	(Give I	ent's Usual Occ kind of work dor OO NOT use retii	e during most of wo	rking	16b. Kind of Busin	ess/Industry
d withir	giene. er than the Me	Omo	Elementary/Secondary (0-12)	College (1-4 or 5+) N/A		N/A_			N/A	
be file	event,	Be	17. Father's Name (First, Middle, Lest) Charles E. Chaffma	n Ir			18. Mother's Na  Amanda	me (First, Middle,  A. Good	Maiden Surname)	
should	and Me mark umatic	ပ	19a. Informant's Name/Relationship (Typ		19b. Mailin	g Address (Stre	et and Number or R			te, Zip Code)
and 2	fealth a m 27 ls her tra		Amanda A. Good/ Mot		2362	Researc	h Ave.,La	nsdowne,	, Marylan	
Pages 1	ent of H		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ Ro 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	cemetery, cren	natory or other p Cremator	ry Oct.		Glen Bur	
ermit.	Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than any injury or other traumatic event, the <u>Magone.</u>		27. Signature o Funeral Service Licenses	00 1 1	ÂÎ	BROSE A	UNERAL HO	ME OF LA	ANSDOWNE	
	으느ㅎ이		23a. Part 1. Enter the disease, or complic	cations that caused the death	h. Do not ent	719 Hamr er the mode of c	nonds Ferr lying, such as cardia	y Rd. La ic or respiratory ar	ansdowne,	Approximate Interval Between
Ph	ysician		shock, or heart failure. List only one Immediate Cause (Final disease or condition	Scizure d	isorde	er				Onset and Death
	Medical aminer		resulting in death)	Due to (or as a conseq	uence of):					
		ner	Sequentially list conditions, if any, leading to immediate gasos. Enter Underlying	Due to (or as a conseq	uence of):					
ecuted	and Il-transi	Examiner	Cause (Disease or injury that initiated events cresulting in death) Last	Due to (or as a conseq	uence of):					
or ou,	g physician and as the burial-transit	edical	L <sub>d</sub>							
ertifical	ling physe as the	/Mec	IF FEMALE:	3c. If yes, outcome of pregna	ancy				23d. Date of	of delivery
death ce	by the attending etached for use a	Physiclan/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No	1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown		Ectopic pregna Other (specify)			Month	
hat the	d by the		9 Unknown  Part II. Other significant conditions con		sulting in the u	ınderlying cause	given in Part I.	23e. Did to	obacco use contrib	ute to the cause of death?
aw requires t	n signe ruld be	ed by						1 🗆 1	Yes 2 KNo 3	☐ Probably 4 ☐ Unknown
taw re	nas bee je 2 shc	Completed		-				24a. Was a autop perfo	osy prio rmed? dea	re autopsy findings available or to completion of cause of ath?
	ificate l	Be Co	25. Was case referred to medical				26. Place of De	ath (Check only or		Yes 2 🖔 No
Ol VI	his cert al direct	ျာ	I les 2 pino		ER/Outpatier	t 3 L DOA		Home 5 Resid	dence 6 Other	
Attending P	th. : After t e funer	ation:	27. Manner of Death  1 Natural 5 Pending  2 Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	v	/ork? ☐ Yes 2 ☐ No	200. Describe i	now injury occurred	
the Hospital or Attending Physician: The law requires that the death certificate be executed	within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use	Certification:	3 Suicide 6 Could not be determined	28e. Place of injury - At he building, etc. (Specif		eet, factory, offic	е	28f. Location ( City or Tow		or Rural Route Number,
Spital	hours a		29a. Certifier 1 Certifying Phys	 sician: To the best of my kno ner; On the basis of examina	owledge, death	n occurred at the	e time, date and place	e, and due to the	cause(s) and mann	ner as stated.
the Ho	thin 24 the Fu mplete	Medical	one)  29b. Signature and title of certifier	and manner stated.	20011 4110/01 111		nse number .		29d. Date signed (	
٠	≥ <b>5</b> 8		, am	MD			006733			23, 2008
	5		30. Name and address of person who co		m 23a) (Type,	Print)	600	North Wo	lfe St. Ralt	imore, MD, 21287
	Sta	ate	31. Date filed (Month, Day, Year)	32, Registrar's Signa	ature			A TOTAL TO	ot, built	,,

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year 2008 2:20G.M Warren Carroll /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Agnes Hospital Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 X M 2 □ F MD 90 Director 212-18-5961 Nov. Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, Its Modical Examination, ust be retilled at Director 1 ☐ Yes 2 X No MD Baltimore Lansdowne 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 2807 Hammonds Ferry Rd. Funeral 12. Was Decedent Ever in U.S. Army Army Science 2 No 1/1943 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 XYes 2 If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2X No Be Completed by If Yes, Give Year or Dates: **-**10/1943 Specify Specify: 3 XWidowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Steam Fitter Local 486 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Earl Lewis Carroll ပ Mabel A. Clark 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hammonds Ferry Rd., Lansdowne, MD 21227 Linda Creamer - Daughter other t Department of Heal Important; If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 10/20/08 Marriottsville, MD Crestlawn Mem. Garden's 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home, Inc. 21. Signature of Funeral Service Licensee 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** da disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 1 Tyes 2 TNo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ JUNICULE 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 1 □ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

The law requires that the death certificate be executed burial-tran Division of Vital Records, P.O. Box 68760. the as nse s is been signed by the should be detached certificate After this Hospital or Attending To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: A filled in by completely

Baltimore, Maryland

Pages 1

3+1

State Registrar

31. Date filed (Manth, Day) Year)

(Check only one)

29b. Signature and title of ertifie

29c. License number (2) 52746

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Choice Core Balf Www. 725 hNIK 32. Registrar's Signature

# ■ Baltimore, Maryland 21215-0036

	Ph /ľ Ex	ysician Medica aminei
Box 68760, 1	ath certificate be executed	ttending physician and or use as the burial-transit

Division of Vital Records, P.O. B

		For State Registrar	State of	f Marylar		partment of t e <i>rtificate of</i>			giene Reg. No.	0000	33800
Physicia	n	1. Decedent's Name (First, Middle	e, Last)  MARIE LO	TO THE	CRONT	C F		2. Date of De 10/17	ath Dav	Year	3. Time of Death 8:00 A M
/Medica Examine		4a. Facility Name (If not institution			GROIN		r Location of Death			County of Death	0:00 A
Funeral		Glen Burnie He	6. Sex	7. Age (In yrs.		Glen	Burnie			Anne Ar	place (State or Foreign
Director		220-14-9996	1 □ M 2 🗹 F	8	3 2 Yrs.	World Days	Tiodis Willi.	03/31	719	26 Mar	yland
and and		Usual Residence of Decedent  10a. State 10b. County		10c. C	ity, Town or	Location					10d. Inside City Limits
with the Maryland a or 28a-f show by notthed at	ţ	MD Anne	Arundel		Pasad	lena, MD					1 □Yes 2 No
th the	)irec	10e. Street and Number				10f. Zip Code			10g. Cit	izen of What Cou	ntry?
23a c	<u></u>	182 Dale Ro	ad			2112	22		U	J.S.A.	
filled within 72 hours after death with the Maryland filled within 72 hours after death with the Maryland, or items 23a or 28a-f show ant, the Madical Exemination could be notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 ☑ Mar  3 □ Widowed 4 □ Divorced	12. Was Dece Armed For 1 □ Yes If Yes, Giv Year or Da	rces? 2 <b>⊠</b> No ⁄e	J.S. 13	3. Was Decedent of H If Yes, specify Cub 1 □Yes 2 ☑No	Hispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	)-	14. Race - Ameri Black, White, Specify:	etc.
2 hour	ted	15. Deceder	t's Education	165.	16a. De	cedent's Usual Occup	oation		16b. K	WI ind of Business/In	nite dustry
hin 7% e. an "na Mudi	Completed	(Specify only highe Elementary/Secondary (0-12)	st grade completed) College (1	-4or 5+)	(Gi life	ve kind of work done . DO NOT use retire	during most of wor d)	king			
ygien ygien ier th		9			Hom	emaker				wn Home	9
be fill ntal H	Be	17. Father's Name (First, Middle,					18. Mother's Nan			,	
hould of Mer mark matic	၉	Santo Scall  19a. Informant's Name/Relations		1	10b Ma	iling Address (Street		ephine			n Coda)
nd 2 s lith an 27 is		Raymond J. Cro			1	2 Dale R				D 21122	,
s 1 ar of Hea		20a. Method of Disposition		20b.		position (Name of rematory or other plan		Date		ocation - City or To	
Page nent c int; if		Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		state		hedral Ce	:	21/08	Ba1	timore	. MD
permit. Pages 1 and 2 should be filed within 72 had Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical Once.		21. Signature of Furreral Service	Licensee				ess of Facility G .	J.Gonc	e Fu	uneral	Home, PA
		23a. Part 1. Ent the disease, or shock, or leart failure. List	complications that ca	aused the dea ach line.							Approximate Interval Between
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	-a. Anti	or as a consec	quence of):	reunon	ia				Onset and Death
Examiner		Sequentially list conditions,	b								
red sit	nine	cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (	or as a conse.	kience of):						
execunate and al-trar	Examiner	that initiated events resulting in death) Last	c Due to (	or as a consec	quence of):						
cate be executed physician and the burial-transit	edical		d.								
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Attending Physician: The law requires that the death certific ar death. ector: After this certificate has been signed by the attending p by the funeral director, page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		oirth 2 🗆 Feta nant at time of	al death	B ☐ Ectopic pregnanc D ☐ Other (specify)	су			23d. Date of deliv Month	rery Day Year
law requires that the de as been signed by the 2 should be detached	by P	Part II. Other significant condition	ons contributing to de	eath but not res	sulting in the	underlying cause giv	ven in Part I.	23e. Did t	obacco u	use contribute to t	he cause of death?
en sig								1 🗆 '	Yes 2	DONO 3□ Pro	bably 4 ☐ Unknown
e law re has be	Completed							24a. Was		24b. Were auto	opsy findings available ompletion of cause of
The yate h	Ę							perfo	ormed? 2 <b>∑</b> No	death?	2 Mo
cian; ertific ector,	Be (	25. Was case referred to medica examiner?					26. Place of Dea		one)		
Physi this c	၉	1 Yes 2 No		<u> </u>	· · ·	ient 3 DOA Oth	4 X Nursing H			6 ☐ Other (Speci	fy)
ding I h. After funer	Ö	27. Manner of Death  1 Natural 5 Pendir  2 Accident investi	9 1 '	h, Day, Year)	28b. Time Injury	/ Wor	ry at k?  Yes 2 □ No	28d. Describe	how injur	ry occurred	
Attender death ctor:	lical	3 ☐ Suicide 6 ☐ Could	ant ha	of Injury - At h	ome, farm,		ites Z 🗆 No	28f. Location (	Street ar	nd Number or Run	al Route Number.
al or / s after al Dire	Certification:	4 ☐ Homicide determ	buildir	ng, etc. <i>(Spe</i> c	ify)	street, factory, office		City or To	wn, State	9)	
	Medical (	29a. Certifier 1 Certifyii (Check only one) 2 Medical	ng Physician: To the Examiner: On the ba and mann	asis of examin	owledge, de ation and/or	ath occurred at the ti investigation, in my	ime, date and place opinion, death occu	e, and due to the arred at the time,	cause(s date an	and manner as d place, and due t	stated. o the cause(s)
To the within To the company	Ň	29b. Signature and title by certifie	M	D		29c. Licens			29d. Da	te signed (Month,	Day, Year)
5		30. Name and address of person	who completed cause	e of death (Ite	m 23a) (Typ	e, Print)	1 0-	C	40	R	- 1 1
Stat		DAL Jeet S 31. Date filed (Month, Day, Year)	Sidhu \$2. Bi	egistrar's Sign	ature	Cracu A	ugheray	OW.Z	se	w when	me / NC 106 1
Stat Registra	r	31. Date filed (Month, Day, Year) OCT 2 4 2	008	w &	A STATE OF THE PARTY OF THE PAR	Crain A	0				
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■ Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760,

		_ For	Please	Type or Pri								gible.		
		<ul> <li>State</li> <li>Registrar</li> </ul>				Cer	tificate	of Dea	th		Reg. No.	. 0 0 8	3391	] [
Physicia /Medic		1. Decedent's Name	e (First, Middle, La	(St)						2. Date of D Month	eath Day	Year	3. Time of Death	M
Examin		4a Facility Name (I	11	re street and number)	Balt	move	4b. City, Tov	rn, or Locat	ion of Death	$\cap$	4501	untrof Death	rue	
Funeral Director		<ol> <li>Social Security N</li> <li>217-34-</li> </ol>	9106	Sex I□M 2 <b>X</b> F	je (In yrs. la: <b>70</b>	st birthday) Yrs.	If Under 1 Y Months D	ear If Un ays Hou	urs Min.	8. Date of B (Month, D	irth Pay, Year) 30, 1938	Cot	place (State or Fore intry) <b>Maryland</b>	ign
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filed within 72 hours after death with the Maryland Hygiene. Hygiene. wither than "natural", or items 23a or 28a-f show ent, the Medical Evan har cust by matths death and the matter of	Funeral Director	Maryland		n/a			101 71 0	Baltim	оге			(141)	1 <b>X</b> Yes 2 □ I	
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Physician /Medical		23a. Tin1. Enter the shock, or head immediate Cause (disease or condition resulting in death)	(Final	plications that cause one cause on each li	1200	20	er the mode o	dying, suc	h as cardiac	or respiratory	arrest,		Approximate Interval Between Onset and Death	
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medica	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months? □No	23c. If yes, outcome 1  Live birth 4  Pregnant a	2 Fetal c	death 3 🗌	Ectopic preg				23d.	. Date of deli Month	very Day Year	
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ding th. After	tion	Natural 2 Accident	5 ☐ Pending investigation	(Month, Da	iy, Year)	Injury	м 200.	Work? 1 ☐ Yes	2 □No	26d. Describe	r now injury oc	curred	•	
To the Hospital or Attendiwithin 24 hours after death. To the Funeral Director: A completely filled in by the fi	Certification:	3 Suicide 4 Homicide	6 Could not b determined	e 28e. Place of In	ury - At hom c. (Specify)	ne, farm, stre	et, factory, of	fice			(Street and No own, State)	umber or Ru	ral Route Number,	
To the Hospital or within 24 hours afte To the Funeral Dir.	Medical (	29a. Certifier (Check only one)	1 Certifying Pl 2 Medical Exa	nysician: To the best miner: On the basis of and manner st	of examination	ledge, death on and/or inv	occurred at t estigation, in	he time, da my opinion	te and place , death occu	e, and due to the rred at the time	e cause(s) and e, date and pla	d manner as ace, and due	stated. to the cause(s)	
To th withir To th comp	Me	29b. Signature and	title of certifier	\		~	29c. L	cense numb	ber		29d. Date si	igned (Month	, Day, Year)	
2			$\Delta$	X	X	DO	1	76	126	1	10	1918	X	
'[		30. Name and addr	ress of berson who	completed cause of o	death (Item 2	23a) (Type, F	Print)	Sh.	1 P 7	)12 A	ROA	Nive	WD 212	1
Sta	te	31. Date filed (Mon	th, Day, Year)	32. Registi	rar's Signatu	re diameter	200	au	1 1-6	14	1	ru-C,	1010 610	-1
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DHMH 17 Rev 1/2001

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month BETTY BULL CLARK 10:05 AM OCTOBER 21, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Upper Chesapeake Medical Center Bel Air Harford 8. Date of Birth (Month, Day, Year) Dec. 24, 1 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 1 F Director 215-32-9140 72 Dec. 1935 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show "natural", or items 23a or 28a-f shov edical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland | Harford Forest Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2629 Rocks Road 21050 permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23° any injury or other traumatic natural. Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 1 ☐ Yes 2 No þ Specify. 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Bookeeper Accounting 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Milton James Bull Jr. <u>Viola Mae Gates</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roy E. Clark / Husband Road, Forest Hill, Maryland 21050 2629 Rocks 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Bel Air Memorial Gdn 10-25-08 Bel Air, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. uss 1317 Cokesbury Road, Abingdon, Maryland 21009 Immediate Cause (Final disease or condition resulting in death) **Physician** diopathic /Medical Due to (or w a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of The law requires that the death certificate be executed L be Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 Yes 2 No 9 Unknown Year Day 4□Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed: 1 ☐ Yes 2 ☐ No Division or Vital the Hospital or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) No No Hospital: Inpatient 2 1 Yes 2 ER/Outpatient 3 DOA 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural Accident Injury 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide in 24 hours. the Funeral Dire The certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

State Registrar

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(Check only one)

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29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

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29c. License number

29d. Date signed (Month, Day, Year)

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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			For State Registrar		State	of Ma	ryland		artmer <i>rtificat</i>				lental Hy	/gien	6	008	33	902
F	Physici	an	1. Decedent's Name (First, Mide				_						2. Date of Do	eath		Year	3. Time of	
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with th	a or 2	Dire	10e. Street and Number 1603 Brangle	o D	and				10f. Zip	Code				10g. Ci USA		What Count	ry?	
death	ms 23	<b>Funeral Director</b>	11. Marital Status	:5 N	12. Was Dec	edent E	ver in U.S	5. 13.			ispanic Or	igin? (Spe	ecify Yes or No Rican, etc.)			ace - America	an Indian.	
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Ma nd 2 s lith ar	<u>s</u> = 0	Į.	19a. Informant's Name/Relation Shirley Custis										l Route Numb riotts					
0 0 ~	<b>-</b> -		20a. Method of Disposition  **Disposition 2	3 □ 1	Removal from	State	20b. Pla	ace of Dispo metery, crer	notani ar a	ther place	e)		ate			- City or Tov		
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ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.

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once		21. Signature of Funeral Service Ligensee  M01173  22. Name and Addess of Facility Robert A. Fumphrey Funeral Home, Bethesda-Chevy Chevy Robert A. Fumphrey Funeral Home, Bethesda, Maryland 20814													nevy Chase 0814	e, Inc
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Sta		31. Date filed (Mon	nth, Day, Year)	32 Registr			and I	,			t	ě			- 1/2	
	201		- 10 7 60	Acres City	and the sale	15 C. S.	Service Constitution						<del></del>			

			For State Registrar	State of Mary		artment rtificate			and Me		giene Reg. No.	800	339	104
e de	Physici	an	1. Decedent's Name (First, Middle, Last)						1	2. Date of Dea Month	Day	Year	3. Time of	
	/Medic		Mary 0'		nshaw					October			6:11	Рм
321	Examir	ner	4a. Facility Name (If not institution, give s 3204 Winnett Road			Ch	nevy	Chas	e		M	ontgome	ery	
- to	Funeral Director		003-03-2036	345	yrs. last birthday)	If Under Months	1 Year Days	If Under	Min.	8. Date of Birth (Month, Day September	23,19	9. Births Cour Verm	olace (State on try)	or Foreign
	land w		Usual Residence of Decedent  10a. State 10b. County	10	c. City, Town or Lo	ocation						1	Od. Inside C	ity Limits
	Mary Inch	to	Maryland Montgomer	у	Chevy Ch	ase						į	1 🗆 Yes	2 📉 No
	or 288	irec	10e. Street and Number			10f. Zip	Code				10g. Citizer	n of What Cour	ntry?	
	23a c	raic	3204 Winnett Road				208	315			Uni	ted Sta	ates	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23e or 28e-f show styl hjury or other traumatic event, the Medical Exerciting fund the colling an ance.	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 M Widowed 4 Divorced	Was Decedent Evel Armed Forces?     March Yes 2 No If Yes, Give Year or Dates:		Was Deced If Yes, spec 1 ☐ Yes 2		spanic Origon, Mexican Specify:	gin? (Spec i, Puerto R	cify Yes or No- Rican, etc.)		Race - Americ Black, White, pecify:		
Maryland 21215-0036	ithin 72 ho nen "netur Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	(Give	dent's Usua kind of wor DO NOT us	k done d	urina most	of workin	g	16b. Kind	of Business/In	dustry	
121	be filed within tal Hygiene. d other than "		12 17. Father's Name (First, Middle, Last)		Book	kkeepe		10.11.1		.=		1 Estat	:e	
auc	id be f ental h ked ot ic ever	To Be	Thomas F. O'Brien							(First, Middle, len Coi		•		
ary	should and Men a marke umatic	-	19a. Informant's Name/Relationship (Type		19b. Mailir	ng Address	(Street a			Route Number			Code)	
	and 2 salth a n 27 ls		Catherine O. LeStra			or being the last of the last		e Lar	ne, S	ilver S	Spring	g, Mary	land 2	.0906
altimore,	Pages 1 nent of H ant: If Iter ury or oth		20a. Method of Disposition  1 ፟ Burial 2 □ Cremation 3 □ R  4 □ Donation 5 □ Other (Specify)	emoval from State	cemetery, crei Dak Hill	matory or ot	her place		Octob 13, 20	er		ion - City or To		
Balt	Dermit. Departr Importe any Inje		21. Signature of Funeral Source Licenses	-	01305 Ro	Name and bert A. 57 Wisc	Address Pumi Consir	ohrey Avenu	Funera Le, Be	l Home/I thesda, I	Betheso Marylar	la-Chevy nd 20814-	Chase, -3501	Inc.
J			23a. Part1. Enter the disease, or complication shock or heart failure. List only on	cations that caused the e cause on each line.	death. Do not ent	er the mode	of dying	, such as	cardiac or	respiratory arr	est,		Approximat Interval Bet Onset and	te ween
*	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Atherosc		. cc	and	iova	15 CM	lan a	lisea	se	yea)	
**	Examiner			Due to (or as a co	nsequence of):								1	
	led sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	nsequence of):					· · · · · · · · · · · · · · · · · · ·				
20,	icate be executed physician and s the burial-transit	il Exan	that initiated events cresulting in death) Last	Due to (or as a co	nsequence of):									
38760,	physic physic the b	dical												
.O. Box (	The law requires that the death certificate be executed te has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	Bc. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	Ectopic pre	egnancy ecify)				23d	. Date of delive Month	-	Year
۵.	signed by d be deta	þ	Part II. Other significant conditions con	14		nderlying ca	iuse give	n in Part I.				contribute to the		
Ö	w requir been s should	eted	Alzheimer's	disease	<u></u>					1 🗆 Ye	_		ably 4 □t	
al Records,		Completed								24a. Was a autops perform	sy	4b. Were auto prior to coodeath? 1 \sum Yes	psy findings mptetion of c 2 No	available ause of
Vital	iician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	ospital:			. 1	r		Check only on				
ō	ਜ਼ਿੰ≘ ਜ਼ਿੰ	5	1 Yes 2 No  27. Manner of Death	28a. Date of Injury	2 ER/Outpatien			4 🗆 1401		e 5 Reside			y)	
<u>o</u>	nding lath. r: After e funer	atior	1 Natural 5 Pending 2 Accident investigation	(Month, Day Ye	ar) Injury	м	Sc. Injury Work′ 1 ☐ Y	? es 2 □ N			on injury or			
Division of	al or Atte s after dea al Directo ad in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - building, etc. (S	At home, farm, str pecify)	eet, factory,	office		28	8f. Location (St City or Town	treet and N n. State)	umber or Rura	il Route Num	ber,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical (	29a. Certifier (Check only one) 1 Certifying Phys 2 Medical Examin	ician: To the best of meer: On the basis of exa and manner stated.	y knowledge, death mination and/or in	occurred a vestigation,	it the time in my opi	e, date and inion, deat	d place, ar h occurred	nd due to the ca	ause(s) and ate and pla	d manner as si	ated. the cause(s	;)
	To To the	Σ	29b. Signature and title of certifier  Patricia /	msko 1	May, mo	29c.	License D5	number	2	2	9d. Date si	igned (Month,	Day, Year) COS	
	10		30 Name and address of person who con Patricia Tomsko	Nay, 1119	(Item 23a); (Type, Rockvill	Print) Pik	te, (	3-100	O. R	ockvi,	lle, r	ND 20	1852	
*	Sta Registr		31. Date filed (Month, Day, Year) OCT 2 4 200	82. Registrar's S	Signature	San J	7		,		7			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
amend #17 Per FH G884-10/24/08 JH... 2008 33905

	1- For State amend #17 Fet Fh Good Certificate of Death Registrar Registrar Reg. No.										
Physici ledical Exami	an/	1. Decedent's Name (First, Middle,Last) Shawn D. Crosby			2. Date of Deat Month October 2	Day Year 1, 2008	3. Time of Death 2305 hrs				
		4a. Facility Name (if not institution, give street ar Johns Hopkins Hospital	d number)	b. City, Town, or Location of Baltimore		4c. County of Death					
Funeral Director		5. Social Security Number 216 33 7175 6. Sex	7. Age (In yrs. last birthday) 17 Yrs	If Under 1 Year If Under Months Days Hours		Co	thplace (State or Foreign untry) )				
any	-	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Locati	on			10d. Inside City Limits				
*	tor	MD n/a	Baltimor	e			1 X Yes 2 No				
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Manal Hygiewill min 22 hours after death with the Maryland 27 is marked other than "natural", or items 23a or 28a-f she matic event, the Medical Examiner must be notified at once	Director	10e. Street and Number 636 E. 29 th Street	eet	10f. Zip Code 21218		Og. Citizen of What Cour USA	ntry?				
tems 2.	Funeral		ed Forces?	s Decedent of Hispanic Orig es, specify Cuban, Mexican		14. Race - Ameri White, etc.	ican Indian, Black,				
after de: nl", or i	by Fu	3 Widowed 4 Divorced If Yes, Giv	es 2 X No e Year 1	Yes 2 X No specify:		Specif Black	2				
hours a		15. Decedent's Education (Specify only highes	during me	t's Usual Occupation (Give ost of working life. DO NOT		16b. Kind of Business/	Industry				
36 hin 72 te. than "	Completed	Elementary/Secondary (0-12) Collection Collection	ge (1-4 or 5+) stud	ent		   Mergenthal	er High				
5-0036 led within 7 Hygiene. other than the Medical	Con	17. Father's Name (First, Middle, Last)			's Name (First, Middle, N		CL IIIGII				
ID 21215-0036 should be filed within 7 and Mental Hygiene. 77 is marked other than matic event, the Medica	Be	Shawn D. Crosby , SR.			cquetta Mur						
MD 2 d 2 shoul tth and M n 27 is m umatic	ပ	19a. Informant's Name/Relationship (Type, Print Jacquetta Murray Johns		Address (Street and Num E. 29th St.	Balto, Md	-	e, Zip Code)				
and and featt		20a. Method of Disposition  1 X Burial 2 Cremation 3 Remo	20b. Place of Dispos	ition (Name of cemetery,	Date	20c. Location - City or					
Baltimore, permit. Pages I an Department of Her Important: If ite		4 Jonation 5 Other Specify:	King Mem.	Pk		Balto, Md	l <b>.</b>				
Balt permit. Departi Importinjury		21. Sinature of Funeral Service Licensee	222	ame and Address of Facility aLVIN B. SCTU 412 F. Prosto	iggs Funera	l Home					
Physician		23a. Part I. Enter the disease, or complications t	I LOYPE -	TTC D. FIESU	ni pr. parti	o, Ma. Zizi	Approximate Interval				
/Medical kaminer	8 1	failure. List only one cause on each line.  Immediate Cause (Final disease a. Multiple	Gunshot Wounds and Sho	tgun wounds			Between Onset and Death				
**		or condition resulting in death)  Due to (or	as a consequence of):								
	ner		as a consequence of):								
٦٧ -	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	as a consequence of):								
ecuted and transit		d									
760, cate be execut physician and tran	n/Medical	UNPENDED AMEND				22d Data of deliver					
3876 rtificat ling ph	an/M	Oh Mas decedent reconnect in the	yes, outcome of pregnancy ive birth 2 Fe	tal death 3 Ectopio	c pregnancy	23d. Date of deliver Month	y Day Year				
lox 687 leath certific e attending properties as the	Physicia	1 Ves. 2 No. 9 Haknows 4	regnant at time of death 5 Ot Inknown	her (Specify)							
<b>T</b>			ing to death but not resulting in the u	inderlying cause given in Pa	art I. 23e. Did to	bacco use contribute to	the cause of death?				
S, P.O.  irres that the r signed by the detache	ed by					s 2 No 3 Pro					
of Vital Records, ng Physician: The law require the continue has been si menal director, page 2 should b	Completed				24a. Was		utopsy findings available completion of cause of				
<b>0</b> 2 ⊢ .ગ △	Com				1 ✔ Yes		es 2 No				
Vital   ysician: his certifi director,	Be	25. Was case referred to medical examiner?	Inpatient 2 ✓ ER/Outpatient	26.Place of Death  3 DOA Other;		Residence 6 Othe	ır:				
1 of Viding Physic	٦: T	1  ✓ Yes 2 No 227. Manner of Death 28a.	Date of Injury 28b. Time of I		? 28d. Describe	how injury occurred					
<b>-</b>	ation	Natural 5 Pending Oct	21, 2008 can 2223 hrs	1 Yes 2 🗸	No Subject sho	Ι					
Division  To the Hospital or Attendir within 24 hours after death.  To the Funeral Director: A completely filled in by the fu	Certification:	Suicide Could not be	Place of Injury - At home, farm, stree cify) Local Street	et, factory, office building, et	tc. 28f. Location (Sor Town, S	Street and Number or Ru State) North Clinton Street, I	ural Route Number, City				
Hospital 24 hours a Funeral tely filled		4 V Homicide	e best of my knowledge, death occur	red at the time, date and pla							
To the within To the complet	Medical	one) 2 Medical Examiner: On the b	asis of examination and/or investigat								
	Š	29b. Signature and title of certifier		29c. License number		29d. Date signed (Mc					
		and odd	source of death (New POC)	O.C.M.E.		October 22, 200	0				
7		<ol> <li>Name and address of person who completed Ana Rubio MD. Assistant Medic</li> </ol>		treet, Baltimore, MD	21201						
S	ate		2. Registrar's Signature	V							
Regis	rar	OCT 2 3 2008	popular de la la la la la la la la la la la la la								

State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	State of Marylan	•	rtificate of L		-	Reg. No.	ΩΩ	33906
	Physicia	ın	1. Decedent's Name (First, Middle, Last)	2.516				2. Date of De Month	Day_	Year	3. Time of Death 02:15 AM
T.	/Medic		4a. Facility Name (If not institution, give st	reet and number)		4b. City, Town, or	Location of Death	Octobe	4c. County o	2008 of Death	02.13.11
	LAdiiiii	61	JOHNS HOPKINS				more				
	Funeral Director		5. Social Security Number 6. Sex 1 Usual Residence of Decedent	7. Age (In yrs. 76	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da May 12	th ay, Year) , 1932	9. Birthpla Countr Mary	
	yland how		10a. State 10b. County		y, Town or Lo					100	d. Inside City Limits
	28a-f s	ecto	Md. Baltimo	re		undalk			10 000 100		1 □ Yes 21X No
	ath with the 23a or 2	Funeral Director	1314 Delvale Ave.				222		10g. Citizen of WI	P	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examinar must be notified at once.	þ	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	2. Was Decedent Ever in U.: Armed Forces? 1 ☐ Yes 2 ※ No If Yes, Give Year or Dates:		Was Decedent of H fYes, specify Cuba I∐Yes 2 ∰No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)	14. Race Black Specify:	America K, White, etc. Whi	c.
15-0	n 72 h	letec	15. Decedent's Educa (Specify only highest grade	tion completed)	(Give	dent's Usual Occup kind of work done o OO NOT use retired	during most of work	ing	16b. Kind of Bus	siness/Indu	istry
212	d within giene. er than	Completed	Elementary/Secondary (0·12)  11 Years	College (1-4or 5+)		House Wif			Own I	Home	
gud	be file ntal Hy ed othe event,	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle	, Maiden Surname	9)	
ıryla	should nd Mer marke imatic	၉	Thomas C. Baumer  19a. Informant's Name/Relationship (Type	e. Print)	19b. Mailin	ng Address (Street		J. Barai		State. Zip C	Code)
, Ra	is 1 and 2 sof Health are item 27 is cother trau		David Darr	Son	T.	Sparrows			•		
Baltimore,	Pages 1 ament of He ant: If iten ury or oth		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)			sition (Name of natory or other place eart Of J		per 25,	20c. Location - C		aryland
Balt	permit Depart Import any Inj once.		21. Signature of Funeral Service Licenses	onvelle	22 Cc 7	Name and Address Onnelly F 110 Solle	ss of Facility uneral Ho rs Point	ome Of I Road, I	Dundalk, Dundalk.	P.A.	21222
			23a. Part 1. Enter the disease of complica shock, or heart failure. List only one	cause on each line.	Do not ente	er the mode of dyin	g, such as cardiac	or respiratory a	rrest,	í	Approximate Interval Between Onset and Death
4	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Respirato Due to (ras a consequence	vy to	ulure				-   0	1 hours
	Examiner		Sequentially list conditions b.	Cardiac o		st				3	3 days
	ted sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Mybcardi	1 1					- 1	
o,	rificate be executed ig physician and as the burial-transit		that initiated events c. resulting in death) Last	Due to (or as a consequ		nfarct	101				
68760,	cate be ohysici the bu	dical	d.								
	ath cel	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown	c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	Ideath 3	Ectopic pregnancy	у		23d. Date Mon	of deliver	y Day Year
, P.O.	res that the de signed by the be detached f		Part II. Other significant conditions contr	ibuting to death but not resu	ulting in the ur	nderlying cause give	en in Part I.	23e. Did 1	obacco use contri	bute to the	cause of death?
rds	w requires been sign should be	ed by		-				1 🗆	Yes 2□No :	3 ☐ Proba	ibiy 4 Dunknown
$\alpha$	The ate h	Completed						24a. Was auto perfo 1 □Yes	psy ormed? de		sy findings available ipletion of cause of
Vita	Physician: The rhis certificate h ral director, page	Be	25. Was case referred to medical examiner?	spital:		othe Othe	26. Place of Dear				
o	ding Phys h. After this funeral di	n: To	1 Yes 2 No 100 27. Manner of Death	1 1 propatient 2 2 28a. Date of Injury (Month, Day, Year)	ER/Outpatien 28b. Time of Injury	IL 3 LI DOA	y at		dence 6 ☐ Othe how injury occurre		
Division of Vital	I or Attending after death. I Director: After d in by the fune	icatio	1	28e. Place of Injury - At ho		M 1 🗆	Yes 2 □ No	20f Location (	Change and Number	as Duml	Doute Mumber
<u>≥</u>	To the Hospital or A within 24 hours after To the Funeral Direct completely filled in by	Certification: To	4 ☐ Homicide determined	building, etc. (Specif	v) 			City or To			
	he Hosp in 24 hot he Fune pletely fi	Medical	29a. Certifier  (Check only one)  1 ☐ Certifying Physi 2 ☐ Medical Examine	cian: To the best of my kno er: On the basis of examina and manner stated.	wledge, death tion and/or in	n occurred at the tir vestigation, in my o	ne, date and place pinion, death occu	, and due to the rred at the time,	cause(s) and mar date and place, a	nner as sta nd due to t	ited. the cause(s)
	Vith Com	Σ	29b. Signature and title of certifier	· ND		29c. Licenso			29d. Date signed		
			30. Name and address of person who com	pleted cause of death (Item	1 23a) (Type	Print)	-000	(	xtober	23	,2008
			Ariel Green MI	D 4940 5	aster	n Aver	nue, Bo	Himor	re, Mary	lano	1 21224
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture	march 1	•		,		

DHMH 17 Rev 1/2001

			For State		epartment of Health and M Certificate of Death		2000	3390
			Registrar  1. Decedent's Name (First, Middle, Las		Derillicate of Death	Reg. N 2. Date of Death	lo.	3. Time of Death
	Physici		celestrie	Doyle			ay Year 2008	2:25PM
1	/Medic Examin		4a. Facility Name (If not institution, give		4b. City, Town, or Location of Death		c. County of Death	
. 14.10			University of Maryland		Baltimore		N/A	
	Funeral		5. Social Security Number 6. Se	7. Age (In yrs. last birtho	Months Days Hours Min	8. Date of Birth (Month, Day, Yea	9. Birthpl	ace (State or Foreign try)
	Director		Usual Residence of Decedent	7 36	0.	May 23,1	952 Ma	syland
	yland how		10a. State 10b. County	10c. City, Town o	r Location		10	d. Inside City Limits
	e Mar sa-f sl	ctor	Md. N/A	Bal	timore			1. Yes 2 □ No
	ift the	Director	10e. Street and Number	# 7 .	10f. Zip Code	10g. C	Citizen of What Count	ry?
	s 23a		1121 Ellico	11 Drivewa	y 21216	if . V N -	USA	- Indian
	ter de	Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U.S. Armed Forces? 1 □Yes 2 ◯No	<ol> <li>Was Decedent of Hispanic Origin? (Spurif Yes, specify Cuban, Mexican, Puerto</li> </ol>	Rican, etc.)	14. Race - America Black, White, e	in Indian, tc.
21215-0036	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ent, if as fledical Exar it ar must be redified at	þ	3 ☐ Widowed 4 🌠 Divorced	If Yes, Give Year or Dates:	1 □Yes 2 No Specify:		Specify: P. 1	nok
5-0	72 ho 'natuı	Completed	15. Decedent's Edi (Specify only highest grad	ucation 16a. D	ecedent's Usual Occupation Give kind of work done during most of worki ife. DO NOT use retired)	16b.	Kind of Business/Ind	ustry
12	vithin ane. <b>than</b> "	mp	Elementary/Secondary (0-12)	College (1-4or 5+)	· · · · · · · · · · · · · · · · · · ·	1 1 0		Calless
	filed v Hygid Sther i	ပိ	17. Father's Name (First, Middle, Last)	e Mar	18. Mother's Name	(First, Middle, Maide	Surname)	Correge
<u>a</u>	lid be lental ked c	To Be	Tervey R	ich	Lillia	o Ma	dison	
Maryland	shou and N s mar	-	19a. Informant's Nam /Relationship (7	(SOn) 19b. N	Mailing Address (Street and Number or Rura	al Route Number, City	or Town, State, Zip	Code)
	and 2 ealth n 27 I		Mr. Larry D	oyle 25	133 Brookfie	ld Ave.	Balta M	d, 21217
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygione. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, that Medical Exactinations be notified at once.		20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from State cemetery,	isposition (Name of crematory or other place)	Date 20c.	Location - City or To	vn, State
Ē	it. Pa rtmen rtant: njury		4 ☐ Donation 5 ☐ Other (Specify	Green		28/2008 E	salto. 1	Md.
Ba	perm Depa Impo any I		21. Signature of Funeral Service Licens	C. Russ	Joseph L. Russ F	uneral H	one, P.A.	
			23a. Parr I. Enter the disease, or comp shock, or heart failure. List only o	lications that caused the death. Do no ne cause on each line.	t enter the mode of dying, such as cardiac	or respiratory arrest,	1	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	· Panciatobilian	Adenocarcinoma			Onset and Death
1	/Medical Examiner		resulting in death)	Due to (or as a consequence of)				
		ē	Sequentially list conditions,	b	· .		-	
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	•				
o,	e exec ian an irial-tr	Exa	resulting in death) Last	Due to (or as a consequence of)				
68760	eath certificate be executed attending physician and for use as the burial-transit	edical		d				
9 ×	ding p	/Me	IF FEMALE:	23c. If yes, outcome of pregnancy				
Box	law requires that the death cert as been signed by the attending 2 should be detached for use a	Physician/M	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delive Month	ry Day Year
P.O.	w requires that the de been signed by the should be detached	hysi	1 □Yes 2 ☑No 9 □ Unknown	9 Unknown	<u> </u>			
ώ.	ss that gned b	by P	Part II. Other significant conditions co	ntributing to death but not resulting in th	ne underlying cause given in Part I.	23e. Did tobacco	use contribute to the	a cause of death?
g	equire sen si ould b					1 ☐ Yes	2 ☑ No 3 ☐ Proba	ably 4 Unknown
ပ္ပ	e law r has be	Completed				24a. Was an autopsy	prior to con	osy findings available oppletion of cause of
Vital Records,	ate Jag	Son				performed?	death? lo 1 □ Yes	2 🗆 No
	Physician: r this certificaral director, p	Be	25. Was case referred to medical examiner?  1 ▼ Yes 2 □ No	Hospital:	26. Place of Death			
ō	y Physer this eral dii	7: To	27. Manger of Death	28a. Date of Injury 28b. Tin	ne of 28c. Injury at	me 5 Residence 28d. Describe how inj		)
<u></u>	Attending Ph r death. ector: After th by the funeral	atio	1 Matural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year) Inju	ıry Work? M 1 ☐ Yes 2 ☐ No	Í	·	
Division of	r Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural te)	Route Number,
	oital o urs afi ral Di	Cer					·	
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi	edical	29a. Certifier 1 ✓ CertifyIng Phy (Check only one) 2 ✓ Medical Exam	rsIcian: To the best of my knowledge, or iner: On the basis of examination and/or and manner stated.	death occurred at the time, date and place, or investigation, in my opinion, death occurrence.	and due to the cause red at the time, date a	(s) and manner as st nd place, and due to	ated. the cause(s)
	Vithii To th	Me	29b. Signature and title of certifier		29c. License number		Pate signed (Month, L	
			) yenflusion	m - physician	DEA # AU4176435	517453	10/15/20	×08
	2		30. Name and address of person who c	ompleted cause of death (Item 23a) (Ty · Bww 22 · Sow	pe, Print) The Greene St. Bad	Thore, 1	11 2120	1
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signature				
	Registr	ar	CCT 2 4 2	008 Maria 18	Society.			

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		ľ	1 - For State Registrar	State	of Marylan	nd / Depa <i>Cer</i>	artmer <i>tificat</i>	nt of H	lealth a Death	and M		giene Reg. No.	2008	33908
	Physicia /Medic		1. Decedent's Name (First, Middle,			Di	itto				2. Date of Dea Month	- 22		3. Time of Death  15:41 PM
	Examin		4a. Facility Name (If not institution,  The Johns Hopkins  5. Social Security Number		mber) 7. Age (In yrs.	last hirthday	Balti	Town, or more	City  If Under		R Date of Birt		ounty of Death	place (State or Foreign
	Funeral Director		239–38–2123 Usual Residence of Decedent	1 □ M 2 XF	7. Age (iii yis.	80 Yrs.	Months		Hours	Min.	8. Date of Birt (Month, Date 12–19	y, Year) -1927	Cour	IVC
:	e Maryland 8a-f show tified at	Director		timore	10c. Ci	ty, Town or Lo Woodla	۸n							10d. Inside City Limits 1 ☐ Yes 2 💢No
3	with th	Dire	10e. Street and Number 2020 Featherbed L	ane			10f. Zi	p-Code 2120	77			10g. Citize	n of What Cour USA	ntry?
2	rs after death ", or items 2: aminer must	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Dec	2∭No ive		Was Dece f Yes, spe 1  Yes	edent of H		gin? (Spe i, Puerto	ecify Yes or No- Rican, etc.)		I. Race - Americ Black, White,	
20.5	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene.  By Injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	's Education t grade completed		life. I	kind of w	ork done d ise retired	during mos	t of work	ing	16b. Kind	of Business/In	ndustry
י מומי	ld be filed vental Hygie ked other i c event, th	To Be Co	17. Father's Name (First, Middle, L Joseph Chapman	ast)							e (First, Middle, Styles	, Maiden S	Gurname)	
ivial y	ind 2 shou alth and M 27 Is mai r traumat		19a. Informant's Name/Relationsh Cherri Phillips/ D								al Route Numb Stown, MD		Town, State, Zip	Code)
ָרָי לְינֵי מילי	Pages 1 anent of He		20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp.		State	Place of Dispo cemetery, crer Stview Co	natory or meter	other plac J		10-30		Kins	ation - City or To ston, NC	
חשו	permit. Departinitmports any Inju		21 Signature of Funeral Service L	M. U	lyhi	92	200 Li	berty	Road,	Rand	allstown,	MD 21		Balto. Co.
< ₽	hysician		23a. Part 1. Enter the disease, or o shock, or heart failure. List o Immediate Cause (Final disease or condition	nly one cause on	each line.	1			ig, such as	cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
	/Medical Examiner	L	resulting in death)	b1//	o (or as a consec Vasive	gast		)		na				
Ś	ate be executed hysician and the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с	o (or as a consec									
	ficate by physic as the t	Medical		d										
. DOA	the Hospital or Attending Physician: The law requires that the death certificate be executed that A hours after death.  The A hours after death.  The Funeral Director, there this certificate has been signed by the attending physician and mpletely filled in by the funeral director, page 2 should be detached for use as the burial-transit mpletely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 N No 9 □ Unknown	1 🗌 Live	utcome of pregn birth 2 Tet gnant at time of on nown	al death 3	Dectopic Other (s	pregnanc pecify)	у			23	3d. Date of delive Month	rery Day Year
62,	uires that the signed by ald be detacted.	þ	Part II. Other significant conditio	ns contributing to	death but not re	sulting in the t	underlying	g cause gi	ven in Part	1.	23e. Did t		e contribute to No 3 □ Pro	the cause of death?
200	The law requite has been page 2 shou	Completed			<del>-</del>						24a. Was autop perfo 1  Yes			opsy findings available ompletion of cause of 2 \( \square\$ No
A 150	sician: Th certificate irector, pa	Be	25. Was case referred to medical examiner?	Hospital:		EB/Outration		Oth	or:		Check only o		Other (Specia	
5	ding Phys h. After this ( funeral di	tion: To	27. Manner of Death  1 Natural 5 Pending investig	28a. Date (Mo	<u> </u>	ER/Outpatier 28b. Time o Injury		28c. Injur Worl	y at		28d. Describe I			y)
	To the Hospital or Attending Physician: The is within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi	200. 7 100	e of injury - At h ding, etc. (Specit		eet, facto	ry, office			28f. Location ( City or Tow		Number or Rui	ral Route Number,
:	ie Hospit n 24 hour ie Funera	edical (		g Physician: To th Examiner: On the and ma										
	withi	Ž	29b. Signature and title of certifier	b. Signature and title of certifier . M.D.						)			signed (Month,	
	m		30. Name and address of person Trung Q. VI	who completed ca		em 23a) (Type,	Print)			600	North Wo	olfe St	, Baltimo	re, MD, 21287
	Sta		31. Date filed (Menth, Day, Year)		Registrar's Signa	ature	)						- M. L.	

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**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-07868 State of Maryland / Department of Health and Mental Hygiene Melissa Jean Disney Certificate of Death Reg. No. 1. For State Registrar Date of Death 1. Decedent's Name (First, Middle,Last) Month Day October 19, 2008 Physician/ 1315 hrs ISNE JEAN NELISSA Medical Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore County** Owings Mills 9929 Lyons Mill Road Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 24Hrs. 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number **Funeral** Hours Months 8 Country) June Director Yrs M 2/ F 216 66 6166 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location lob. County Yes 2 BALTIMORE : 23a or 28a-f show : notified at once. 10g. Citizen of What Country? hours after death with the Maryland Director 10e. Street and Number LYONS ROAN MILL Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. Funeral 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 2 X No Yes Specify: WHITE Yes 2 No specify: If Yes, Give Year Divorced marked other than "natural", cevent, the Medical Examiner 16b. Kind of Business/Industry ģ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed vermit. Pages 1 and 2 should be filed within 72 hou-vepartment of Health and Mental Hygiene. portant: If item 27 is marked other. College (1-4 or 5+) Elementary/Secondary (0-12) OWN Homemaken 0 12 18.Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) RTHUR DISNE Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2 LIH/esTOWN 23 Clover Orive BROTHER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition Sykesville, mo Removal from State Cremation 3 Burial 2 10/24/08 AKE VIEW MEN PK Baltimo
permit. Pages
Department o
Important: 1 Donation 5 Other Specify: JUMBRUN FI & MON Co. 22. Name and Address of Facility Signature of Funeral Service Licensee ELDERSBURG MD 21784 6028 SYKOVILLE Rd Approximate Interval Til. Enter the dilea e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Onset and Physician failure. List only one cause on each line. a. Mixed drug (Citalopram and quetiapine) intoxication Death Medical Immediate Cause (Final disease aminer Due to (or as a consequence of): or condition resulting in death) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last AMENDED 23a,2/,28a-f, perME, G885 11/26/08 TT and Physician/Medical X UNPENDED signed by the attending physician be detached for use as the burial The law requires that the death certificate be 23d. Date of delivery Box 68760 23c. If yes, outcome of pregnancy E EEMALE. Day Year 3 Ectopic pregnancy Month 23b. Was decedent pregnant in the Fetal death Live birth 2 past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 V Unknown Unknown 9 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions o 1 Yes 2 No 3 Probably 4 V Unknown ģ 24b. Were autopsy findings available Completed 24a. Was an Records, prior to completion of cause of autopsy performed? death? this certificate has b director, page 2 sh 1 🗸 Yes 2 No ✓ Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical To the Hospital or Attending Physician: Other<sub>4</sub> **Division of Vital** Be Residence 6 V Other: Scene Nursing Home 5 Hospital: DOA examiner? ER/Outpatient 3 Inpatient 2 this 1 V Yes 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury subject ingested medications 27. Manner of Death After Certification: Yes 2 X No Fnd 10/19/08Fnd 1300 hrs 1 Natural Pending To the Funeral Director: completely filled in by the 28f. Location (Street and Number of Rural Route Number RCH) or Town, State) Investigation 28e. Place of Injury -Athome, farm, street, factory, office building, etc. residence 2 Accident or Town, State) 9929 Owings Mills, 3 X Suicide Could not be determined Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 W Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

Registrar

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OCME 2006

State

30. Name and address of person who completed cause of death (Item 23a)

2008

Russell Alexander MD.

Assistant Medical Examiner

egistrar's Signatu

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

CIOBER

00ME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician**  $p^{M}$ 2008 4:23 18. PRESTON E. EASLEY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner BALTIMORE EMERALD ESTATES Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1**X**X M 2□ F 81 OCT 22, 1926 TENNESSEE Director 413.28.6749 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 28a-f show traumatic event, the Medical Evaminer must be notified at 1)(∑Yes 2 □ No Director BALTIMORE MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ö USA 21211 3855 GREENSPRING AVE. #242 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. . Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 72 hours after 1√X Never Married 2 Married 1√yYes 2 □ No If Yes, Give Year or Dates 944 -1950 Baltimore, Maryland 21215-0036 ō 1 ☐ Yes XXX No Specify. Specify: WHITE à 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) filed within Hygiene. CONSULTING ENGINEERING **ENGINEER** 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be f ESTHER FRANCES CAMPBELL MOSS ELLIS EASLEY 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1 and 2 s' f Health a 200 W. 16th ST. #7H, NEW YORK, NY 10011 **BROTHER** DOUGLAS EASLEY other 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages
Department of
Important: If Its
any Injury or o Pages to 1 ☐ Burial 2 XXCremation 3 XXRemoval from State 5 ☐Other (Specify) OCT 21, 2008 BALTIMORE, MD 4 Donation BAYVIEW CREMATORY INC. of Elineral Service 22. Name and Address of Facility 21. Signatur FINK FUNERAL HOME, P.A. 426 CRAIN HWY. S., GLEN BURNIE, MD M01148 CRECORY KINK ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between ter the disease, or a mplicat shock, or Vieart failure. e on each line Onset and Death Immediate Cau (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine death certificate be executed physician and s the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical attending pt IF FEMALE: . If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 5 Other (specify) signed by the a P.O. 2 No 9 I Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ DEMENTIA 1 Yes 2 No 3 Probably 4 Unknown s been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has al director, page 2 autopsy 2 1 ☐ Yes 1 □Yes Be 25. Was case referred to medica 26. Place of Death (Check only one examiner? Other: 21 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes Medical Certification: To To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 2 Accident (Month, Day, Year) Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, 29c. License numbe 29b. Signature and title of certifier 08 30. Name and address of person who completed cause of death (Item 23a) (Type, F 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

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Registrar

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			1 - State of Maryland State of Maryland		artment of F			ene	0.001
	Physici /Medic		Decedent's Name (First, Middle, Last)  I DA	Е	LKIN		Date of Death Month CTOBER	20 2008ar	3. Time of Death 5:00 P M
1	Examir		4a. Facility Name (If not institution, give street and number) MILFORD MANOR NURSING HOME		BALTIMOR			4c. County of Death	
	Funeral Director		5. Social Security Number 126-18-3995  Usual Residence of Decedent	a <i>st birthd</i> ay) Yrs.	Months Days	Hours Min. 8.	Date of Birth (Month, Day, Y 9/18/19	(ear) 9. Birth Cou	place (State or Foreign intry) NY
	e Maryland Ba-f show	Director		, Town or Lo					10d. Inside City Limits 1 □ Yes 2 🛱 No
	ath with th	eral Dire	16 OLD COURT ROAD			.208		J. Citizen of What Cou USA	intry?
900	be filed within 72 hours after death with the Maryland that Hygiene. Ad other than "natural", or items 23a or 28a-f show event, if a findled Exx. in at must be redflied at	d by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S Armed Forces?  1 □ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 □Yes 2 1 No	dispanic Origin? (Specif an, Mexican, Puerto Ric Specify:	y Yes or No- an, etc.)	14. Race - Amer Black, White Specify:	
21215-0036	vithin 72 h ane. :han "natu	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give life.	DO NOT use retired	during most of working	16	b. Kind of Business/I	ndustry
Maryland 2	be d d d	To Be Co	12 17. Father's Name (First, Middle, Last) SAMUEL WASSERMA		KEEPER	18. Mother's Name (F		HOSPITÄL iden Surname) POLOTN	ICK
, Mar	nd 2 saith ar 27 is r trau	1	19a. Informant's Name/Relationship (Type. Print) MARTIN KINSTLER / SON	5000	HOLL INGT	ON DR., #20	04, OWI	NGS MILLS,	MD 21117
Baltimore,	Pages 1 nent of F int: If ite iry or ot		4 □ Donation 5 □ Other (Specify) SHA	RON G	esition (Name of matory or other place ARDENS	10/23/2	2008	VALHALLA,	NY
Bal	permit. Departn Imports any inju		21. Signature of Funeral Service Licensee			STERSTOWN R	OAD - P		MD 21208
	Physician /Medical		23a. Par11. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. A S C V D  Due to (or as a consequence of the condition of the		ter the mode of dyir	ng, such as cardiac or r	espiratory arres	t,	Approximate Interval Between Onset and Death
	Examiner	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  b. Alzheimer.  Due to (or as a consequence of the con		entia				
8760,	ficate be execute physician and s the burial-trans	dical Examine	Catase (Disease or injury that initiated events resulting in death) Last  C	ence of):					
O. Box 6	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  IF FEMALE: 23c. If yes, outcome of pregnat 1 □ Live birth 2 □ Fetal 1 □ Live birth 2 □ Fetal 1 □ Live birth 2 □ Fetal 1 □ Live birth 2 □ Fetal 1 □ Live birth 2 □ Fetal 1 □ Live birth 2 □ Fetal 1 □ Live birth 2 □ Fetal 1 □ Live birth 2 □ Fetal 1 □ Live birth 2 □ Fetal 1 □ Live birth 2 □ Fetal 1 □ Live birth 2 □ Fetal 1 □ Live birth 2 □ Fetal 1 □ Live birth 2 □ Fetal 1 □ Live birth 2 □ Fetal 1 □ Live birth 2 □ Fetal 2 □ No 9 □ Unknown	death 3[	☐ Ectopic pregnand ☐ Other <i>(specify)</i> _	су		23d. Date of deli Month	very Day Year
σ.	w requires that t been signed by should be detac	þ	Part II. Other significant conditions contributing to death but not resu	Iting in the u	nderlying cause giv	ven in Part I.	23e. Did tobac	cco use contribute to	
Vital Records,	ician: The law re certificate has be ector, page 2 sho	Completed					24a. Was an autopsy performe	prior to death?	opsy findings available ompletion of cause of 2 No
f Vit	dir	To Be	25. Was case referred to medical examiner?  1 Yes 2 No Hospital: 1 Inpatient 2	ER/Outpatie	nt 3 DOA Oth	26. Place of Death (Coner:		ce 6 □Other (Spec	ify)
Division of	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification: 7	27. Manner of Death  1 Matural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28b. Time o Injury	M 1 🗆	ryat rk? ]Yes 2 □ No	I. Describe how	injury occurred	
Divi	the Hospital or Attending hin 24 hours after death. the Funeral Director: After mpletely filled in by the funer		4 Homicide determined 256. Place of Injury - A no building, etc. (Specify				City or Town,		
	the Hosp in 24 hot the Fune	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my know and manner stated.	wledge, deat tion and/or ir	h occurred at the ti evestigation, in my o	ime, date and place, an opinion, death occurred	d due to the cau at the time, date	use(s) and manner as e and place, and due	stated. to the cause(s)
D	or time of the property of the	Δ	29b. Signature and title of certifier  MS RayapameMD			se number 00057465		I. Date signed (Month	
	4		30. Name and address of person who completed cause of death (Item N · S · Rajapa Kse, MD 25 Ma	23a) (Type,	Print) Suite 200	, Reisterste	wn, M	0,21136	
N.	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signal	ure					
DHI	MH 17 Rev 1/2	001	OCT 2 4 2008		GINAL				

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2008 2:00P M Ida Helen Field Oct. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Catonsville Ridgeway Manor Nursing Home 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days 1 □ M 2 🗓 F 4, 218-18-6606 83 Jan. Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 28a-f show ir than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director MD Baltimore Catonsville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 21228 Edmondson Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify Specify: White þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "ne any Injury or other traumatic event, The Media once. Elementary/Secondary (0-12) College (1-4or 5+) Housekeeping Factory 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marion Hawkins Goldie Hastings ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1117 Bayard Street, Baltimore, MD 21223 Helen Hawkins - Sister-In-Law 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 10-23-08 Woodlawn, Maryland Woodlawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home, Inc. 21. Signature of Funeral Service Licensee 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): P.O. Box 68760, cate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical IF FEMALE: yes, outcome of pregnancy ☐ Live birth 2☐ Fetal death ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 5 Other (specify) 9 I Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 3 ☐ Probably 1 □ Yes 2 □ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe After this certificate 2 No 1 □Yes ¾ within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

To the Hospital

State Registrar

DHMH 17 Rev 1/2001

Medical

4 Homicide

29a, Certifier

31. Date filed (Month, Day, Year)

and title of gertifier

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29d. Date signed (Month, Day, Year)

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 4, 10 PM 1. Decedent's Name (First, Middle, Last) 2. Date of Death ) ctober 2058 **Physician** DELLA ELIZABETH FINKE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death **Examiner** Bunul If Under 24 Hrs. Washington 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number Funeral 1 □ M 2 🗹 F Months Days Hours Min. 214-88-6587 04/29/1966 Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Mastical Eventine: sust be notified at 28a-f shov 1 Tyes 2 No Director MD Anne Arundel Pasadena 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7743 Outing Avenue 21122 U.S.A. Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify: 9 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Price Analyst Retail Data 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harvey Russell Ratliff, Jr. Mary Kay Chafin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important; if item 27 is any injury or other trau once. Marcella Uhden/Sister 107 Marshy Creek Road, Grasonville, MD 21638 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Holy Cross Cemetery 10/23/08 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility G.J.Gonce Funeral Home, PA 21. Signature of Foneral Service Licenses 169 Riviera Drive, Pasadena, MD 21122 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Non Small (all aucer Lung Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) nis certificate has been signed by the director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ₫ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? yes 2 100 1 Tyes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 I ER/Outpatient 3 I DOA Certification: To this 27. Man or of Death within 24 hours after death, To the Funeral Director: After thi completely filled in by the funeral i 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division of Vital Records, P.O. Box 68760,

the

altimore, Maryland 21215-0036

State Registrar

Medical

31. Date filed (Month, Day, Year) OCT 24

29b. Signature and title of certifier

29a. Certifier

(Check only one)



and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number 0 4 (365

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2008 Year **Physician** 11:45 AM Gluck Nortica October 22, /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Dundalk Genesis Eldercare - Heritage Center 9. Birthplace (State or Foreign Country) New Jersey If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) September 30,1918 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1 □ M 2 □XF 90 215-10-1020 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, If a Medical Expusive routified at once. 10d. Inside City Limits 10c. City, Town or Location 10a State 10h. County 1 □Yes 2 XNo Maryland Baltimore Dundalk Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 2218 Searles Road 21222 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 No Specify: Specify: White 2 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Bendix Corp Assembly Line Worker 8 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Oscar Burke Lillian Worle ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mellette Yeagy Daughter 2218 Searles Road, Dundalk, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place)
Bayview Crematory 20c. Location - City or Town, State October 25 20a. Method of Disposition 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State 2008 Baltimore, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. 6 not enter the mode of dying, such as cardiac or respiratory arrest, PULMONA Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 3 Ectopic pregnancy Month Dav Pregnant at time of death 5 ☐ Other (specify) 9 I Unknown 9 Unknown 23e. Did tobaçor use contribute to the cause of death? Part I Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 🔲 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 1 □ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 NO 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 28b. Time of Injury 27. Mannel f Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 U atural 5 Pending 2 No 1 ☐ Yes investigation 2 Accident 6 ☐ Could not be detempined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

The law requires that the death certificate be executed physician and s the burial-trans Box 68760. attending p signed by the a Ö ۵. Division of Vital Records, been s certificate has briector, page 2 sl or Attending Physician: director this After th funeral hours after death. within 24 hours after death

To the Funeral Director;
completely filled in by the

To the Hospital

Baltimore, Maryland 21215-0036

Certification: To

Medical

29a. Certifier (Check only one) 29b. Signature

10 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

HIGHWA f de No (Item 83a) (Type, Print 10 MARY

State Registrar

31. Date filed (Month, Day, Year)

1

32. Registrar's Signature

and manner stated.

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 3:51P M Richard Walter Gamer October 21, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Upper Chesapeake Medical Center Bel Air 8. Date of Birth (Month, Day, Year) Aug. 17, 1927 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 ☐ M 2 ☐ F Washington, D.C 386-24-5481 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 1 ☐ Yes 2√ No Director Maryland Harford Forest Hill 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21050 United States 1414 Kahoe Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1. □Yes 2 □ No 1944 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 ∏Yes 2 1944-1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify. Completed by 3 ☐ Widowed 4 ☐ Divorced 1950 Year or Dates White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Marketing Specialist Telecommunications 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Luther B. Garner ပ Dorothy Mulligan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1414 Kahoe Rd. Forest Hill, Maryland Dolores Garner / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State oct. 25, 4 Donation 5 Dother (Specify) Bethel Pres. Cemetery White Hall, Maryland 2008 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services Bel 3 Newport Drive Forest Hill, Maryland 21050 21. Signatur of Funeral Ser 23a. Part 1. Enter the disease, or comprications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Dua to (or as a consequence of) Examine if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ð 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □No 24a. Was an 2 3 N 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 npatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Division of Vital Records, P.O. Box 68760, physician attending physical for use as the b cate has been signed by the page 2 should be detached certificate ours after death.

eral Director: After this certifical filled in by the funeral director, it e Funeral within 2

death with the Maryland

Pages 1 and 2 should be filed within 72 hours after

permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 Is any injury or other trau

Baltimore, Maryland 21215-0036

28a-f show

th and Mental Hygiene. 7 Is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Machael Examinar must be motified at

State Registrar

and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) 2008 4

29b. Signature and title of certifier

32. Redistrar's Signature

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 9:39 p<sup>M</sup> Levin Elwood Gallion October 20, 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Abingdon Harford 610 Leight Road If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Hours 1**⊠**M 2□F 75 215-30-0888 Nov. 14, 1932 Maryland Director Usual Residence of Decedent 10d. inside City Limits 10c. City, Town or Location a or 28a-f show the notified at 10b. County 1 ☐ Yes 2 No Director Abingdon Maryland Harford 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number "natural", or items 23a 21009 USA 610 Leight Road by Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Black, White, etc. Armed Forces 1⊠Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married  $L \in V I \cap Ga\}\{1 \cap Ga\}$  Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: 3 Widowed 4 Divorced White I are and Mental Hygresses.
Health and Mental Hygresses
Hearthan "naturation 27 is marked other than "naturation" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Plant Technician Phone Company 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ould be Levin Oler Gallion Edna Georgia Moulsdale Pages 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 Is 610 Leight Road, Abingdon, MD 21009 Juanita Gallion / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 

Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cokesbury U.M.C. Cem. -10-23-08 Abingdon, Maryland McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 21009 21. Signature of Funeral Service Licensee usa 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Metastatic colon cancer 18 months **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter orderlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine certificate be executed burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as the IF FEMALE nse 23d. Date of delivery 23b. Was decedent pregnant

attending physician and for ned by the a signed by

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director.

State Registrar

If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 4□Pregnant at time of death 3 ☐Ectopic pregnancy Year Month Day in the past 12 months? 5 Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ▼ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes 26. Place of Death Check onl one 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Certification: Injury Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the firm of the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

D45530

10-21-2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SUITE 200, 602, S. Atwood, Belair · SIUASALLAM,

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death 8:20 A M October Gloria Lee Gilbert 22, 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Towson Gilchrist If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 2/27/1931 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) Months Maryland 1 □ M 2 🔀 F 217-26-2772 Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits Baltimore Nottingham 1 ☐ Yes 2√☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21236 8302 Tapu Court 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates 1 ☐ Yes ¾ No Specify. Specify: White 3X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Household Finance Secretary 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William D. Brooks Blanche E. Hoeck 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tapu Court Nottingham, Maryland 21236 Robert P. Pizza / Friend 8302 Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Parkwood Cemetery 10/25/2008 Baltimore, Maryland 21. Signature of Funeral Service Maryland 21204 22. Name and Address of Facility Towson, Ruck Towson Funeral Homé, Inc. 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) MESOTHELLOMA MONTHS Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter or derlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 5 ☐ Other (specify). 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 □ No 1 □Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Mulcol Eventine roughbut at once.

Baltimore. Maryland 21215-0036

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Physician:

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To the Hospital within 24 hours at To the Funeral D completely filled Hospital

that the death certificate be

Completed by Funeral Director

Be

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Examine

attending physical for use as the b been signed by the should be detached page 2 s funeral director.

Physician/Medical

Completed by

Be

Certification: To

Medical

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

examiner? 1 Yes 2 No

3 Suicide

29a. Certifier (Check only

4 \( \text{Homicide} \)

27. Manner of Death 1 Natural
2 Accident 5 Pending

investigation 6 Could not be determined Date of Injury (Month, Day, Year)

28b. Time of 28c. Injury at Work?

1 ☐Yes 2 ☐ No

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

and manner stated. 29b, Signature and title of certif

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29d. Date signed (Month, Day, Year) OCTUBER 22; 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DOBERMAN, MD 6565 N CHARLES ST, SUITE 209 BALTIMONE, MB 21204 DANIEUL 31. Date filed (Month, Day, Year)

Registrar



28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1- State amend #21 Per FH G884 10/24/06ertificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month SUSIE I. GILES /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 9 Hours Min. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) 78 Yrs. Birthplace (State or Foreign Country) ocial Security Number **Funeral** 222 16 2206 1□ M 2 T Days Months Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It a Prodical Examinations to prefined at once. Director MD N/A 1 Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 707 N. Linwood Ave. 21205 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 DYes 2 No BLACK Specify: þ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) homemaker 12th home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Walter Briddell unk 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Giles (husband) 707 N. Linwood Ave. Balto, Md. 21205 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Green Mount Crematory Oct.24,2008 Baltimore, Md. 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee

Bernadine V. Scruggs 22 Name and Address of Facility Calvin B. Scruggs Funeral Home 1412 E. Preston St. Balto,Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final neumonia Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). sician and burial-transit Division of Vital Records, P.O. Box 68760, روح Physician: The law requires that the death certificate be execu Due to (or as a consequence of): physician Physician/Medical the attending pl IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) the detached 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 
Unknown director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an has autopsy certificate perforn 2**/**No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 No Certification: To 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA this completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 2 ☐ Accident 5 Pending after death investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only one) the To the within ? 29b. Signature and title of certifier 29c. License number

State Registrar 30. Name and address of person

31. Date filed (Month, Day, Year,

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Bahimore, MD

leted cause of death (Item 23a) (Type, Print)

OO FLOOKIN 32. Registrar's Signature

October 21 Elsa M. Hernandez /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Gilchrist Center for Hospice Care Baltimore Towson If Under 1 Year | If Under 24 Hrs Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Min. 1 M 2 KF Months Hours 58 Director 10/10/1950 243-91-5273 Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a State 10h County 28a-f show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shot injury or other traumatic event, the "Medical Eventine must be notified at Director MD Windsor Mill Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21244 Honduras 8127 Subet Rd Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1-25√es 2 No SpeciMonduras Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Factory of Health and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Assembler 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unk Castro Juan ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Jose Denis Hernandez/Husband 8127 Subet Rd Windsor Mill, MD 21244 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 Department of Important: If its any injury or o once. Oct 24 1 ☑ Burlal 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland 4 Donation 5 Dother (Specify) 2008 Mt Carmel Cemetery 22. Name and Address of Facility 21. Signature of Funeral Service Licensee M01443 Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. er Immediate Cause (Final COT **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed ending physician and use as the burial-tran Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown After this certificate has been signed I funeral director, page 2 should be det 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy perform 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) How 1 Yes 2 No 2 ER/Outpatient 3 DOA Medical Certification: To 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 ⊟ Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No thours after death.

uneral Director: A
ely filled in by the fu 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a

To the Funeral C Ectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only

and manner stated.

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32 Registrar's Signature

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2008

Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend item 20a per Th g884 10-24-08 vt
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Day

Vear

2008

3. Time of Death

3:25A

10d. Inside City Limits

Approximate Interval Between Onset and Death

rears)

Year

NEW 2 INO

Birthplace (State or Foreign Country)

White

Honduras

Black, White, etc.

Month

1 ☐ Yes

29d. Date signed (Month, Day, Year)

October 21,2008

Day

2 □No

2. Date of Death

Month

State Registrar

29b. Signature and title of certifie

31. Date filed (Month, Day,

1 - For State Registrar

**Physician** 

1. Decedent's Name (First, Middle, Last)

DHMH 17 Rev 1/2001

DOME!

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10 A K Ley Comme 6701 N. Charles St. Bolts. Md 2(20 g

29c. License number

		For State Registrar		aryland / D	epartmer <i>Certificat</i>			nd Menta		ene . No.2 () (	8 (	3392	0
Physicia		Marie noin								008	3. Time of Deat 11:33 P		
/Medic Examin		4a. Facility Name (If not institution, give street and number)  Suburban Hospital  4b. City, Town, or Lo						Location of Death  Bethesda			4c. County of Death Montgomery		
Funeral Director		5. Social Security Number 420-09-1565	6. Sex 7. A	ge (In yrs. last birti 90	hday) If Under Months		If Under 24 Hours	Min. 8. Dat	e of Birth onth, Day, Y	(27) 18	9. Birth	place (State or Forentry)	eigr
Maryland I-f show	tor	Usual Residence of Decedent										0d. Inside City Lin	
th with the 23a or 28a ist be noti	al Director	10e. Street and Number 299 Hurley Ave								hat Cou	,		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If time Z7 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Evander rough to notified at once.	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Mar  3 ☐ Widowed 4 ☑ Divorced	If Yes Give	? •No	13. Was Dece If Yes, spe 1 ☐ Yes		spanic Origi n, Mexican, Specify:	in? (Specify Ye Puerto Rican, o	s or No- etc.)	Black	, White,	can Indian, etc.	
within 72 ho giene. r than "natur	Completed	15. Deceder (Specify only higher Elementary/Secondary (0-12)	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+) 2			al Occupa irk done di se retired) Lcer	ition uring most o	of working		b. Kind of Bus Mortga		dustry	
uld be filed Mental Hyg arked other atic event,	To Be C	17. Father's Name (First, Middle, Frederick J. (	1		18. Mother's Name (First, Middle, Maiden St. Clara Billie					·)			
and 2 sho lealth and m 27 is me her traums		19a. Informant's Name/Relationship (Type. Print) Leslie Terner/Daughter  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19 Hickory Hill Court Silver Spring, MD 20								20906-			
t. Pages 1 rtment of H rtant: If ite		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Chesapeake Crematory   6/21/08    20c. Location - City or Town, State    Beltsville, Marylan											
permit Depar Impor any In		21. Signature of Funeral Service	/)	01533				rematio			nd 2	0910-	
Physician /Medical												Approximate Interval Between Onset and Death 3 d q y 5	
cate be executed by physician and the burial-transit	dical Examiner												
Attending Physician: The law requires that the deeth certificate roteth; actor; After this certificate has been signed by the attending physby the funeral director, page 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Ves 2 ☑ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy Month 5 ☐ Other (specify)									ery Day Year		
quires that in signed by uld be detail	ğ								co use contribute to the cause of death?				
The law requii cate has been s page 2 should	Completed	CVA							a. Was an autopsy performe ]Yes 2 [	d? p	rior to co eath?	opsy findings availa impletion of cause	ible of
Physician: The this certificate al director, pag	To Be	25. Was case referred to medical examiner?  1								<u> </u>	fy)		
To the Hospital or Attending Ph Within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	27. Manner of Death  1 X Natural 2 Accident 3 Suicide 4 Homicide  28a. Date of Injury (Month, Day, Year)  28b. Time of Injury at Work? 1 Yes 2 No  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Loc	28d. Describe how injury occurred  28f. Location (Street and Number or Rural Route Number, City or Town, State)				
To the Hospital or Attendiwithin 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical Ce	29a. Certifier 1 Certifyi (Check only one) 2 Medical	ng Physician: To the best Examiner: On the basis and manner s	of examination and	, death occurred d/or investigation	at the tim	ne, date and pinion, death	place, and due n occurred at th	e to the cau ne time, date	ise(s) and ma e and place, a	nner as nd due t	stated. o the cause(s)	
To th withir To th	Me	29b. Signature and title of certific		Mi	290	D 0 0	number 6 2 4 3 5	5		Date signed			
5		30. Name and address of person Sayed Elsay				, R	ockvi	ille.	MD 20	0.850			

State Registrar

82. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 200 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner TIMORE 8. Date of Birth Month, Day, 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday Year) **Funeral** Days 3 North Carolina Months Min 1 X M 2 □ F Director Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d, Inside City Limits 10b. County 10a. State 28a-f show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shoi injury or other traumatic event, the Medical Evaning must be notified at iv Yes 2 □ No Director more 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number d nWood Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: <u>م</u> 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Health and Mental Hygiene. em 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) IVE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ 17, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) ven WOO altimore, Department of Heal Important: If item 2 any injury or other once. OCTOBER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20a. Method of Disposition... Pages 1 12008 Burial 2 Cremation 3 Removal from State 22. Name and Address of Facility 4 ☐ Donation 5 ☐ Other (Specify) ture of Funeral Service License nex 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** LUNG CANCER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Closease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be exect Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Liva birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached EDDIE HARRIS 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Ş</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 □ No 1 □Yes 2 X No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6X Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA HOSPICE Certification: To 28b. Time of 27, Manner of Death Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical Nurse Practitioner stated. 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and title of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

JACKIE JONES,

Day,

2008

31. Date filed (Month

TIMONIUM, MD 21093

CRNP 2300 DULANEY VALLEY RD.

32. egistrar's Signature

# Baltimore, Maryland 21215-0036

P.O. Box 68760 Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 4:45 a М Sarah T. Howard Oct 19, 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number, Examiner Anne Arundel Arnold Future Care Chesapeake if Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Funeral Days Hours Months 1 □ M 2 □ F May 21, 1900 Director 108 Maryland 218-36-0665 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 28a-f show or other traumatic event, the Medical Examiner a ust be notified at 1X Yes 2 □ No Director Hanover Anne Arundel Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö 21076 USA items 23a 7548 Old Telegraph Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married ò 1 □Yes 2 No Specify: þ Specify: Black 3 ₩ Widowed 4 □ Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental Mary Jacobs David Boston ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 is any injury or other trau once. 6442 Grafton Garth Court Glen Burnie, Maryland 21061 Judy Howard 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 10/23/08 Baltimore, Md. 4 Donation 5 Other (Specify) **Baltimore National Cemetery** 22. Name and Address of Facility 21. Signature of Funeral Service License Estep Brothers Funeral Service, P 1300 Eutaw Place Baltimore, Md 21217 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final , Physician ad vanc disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed and a resulting in death) Last Due to (or as a consequence of): physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 mon Month Day Year 5 Other (specify) 1 □Yes 2 No 9 Unknown signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ UnKnown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No After this certificate 1 □ Yes 1 TYes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) funeral 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation death. 1 ☐Yes 2 ☐ No illed in by the fu 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours after To the Funeral Dire 29a. Certifier i 🛈 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number and title of certifie completed cause of death (Item 23a) (Type, Print) Allersville MD 2110

State Registrar

Te 31. Date filed (Month, Day, Year)

24

2008

Vete

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month october Year **Physician** .30 AM HIRSCH ZELDA 2008 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A of Boltimer Balti mere Ustigasti 8. Date of Birth 12/1920 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🛚 F Months Days Hours Min. 87 217-12-6517 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, it e Medical Examiner must be recified at 1 □ Yes 2 No **Funeral Director** BALTIMORE BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21209 2401 SUGARCONE ROAD 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married WHITE 1 □Yes 2 No Baltimore, Maryland 21215-0036 Specify. Specify. à 3 X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. WOMENS CLOTHES SALES permit. Pages 1 and 2 should be filed i Department of Health and Mental Hygid Important: If item 27 is marked other i any injury or other traumatic event, III 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be DAVIS NEEDLE HETTIE HYMAN ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2401 SUGARCONE ROAD, BALTIMORE, MD HEDY GOLDSTEIN / DAUGHTER 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 20a. Method of Disposition ANSONE der EMILIAN (Valle of ANSONE DE CHAIM 1 Burial 2 Cremation 3 Removal from State 10/23/2008 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) SOL LEVINSON & BROS., INC. 22. Name and Address of Facility Signature of Funeral Service Licenses 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 atul M Part 1. Enter the disease; or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease Immediate Cause (Final disease or condition resulting in death) esp motor Idey **Physician** /Medical Due to (or as a consequence of) Examiner Phelymone Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed pancreation and Due to (or as a consequence of): attending physician Physician/Medical the nse ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy for Year Month Day 5 Other (specify) ned by the a I ☐ Yes ₽ ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No has certificate 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death Injury Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

State Registrar 31. Date filed (Month, Day, Year)

Rashy Gal

29b. Signature and title of certifier

Gale MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Since hospital of Rultinge, 2401 W-Belvedore are, MD 32. Registrar's Signature

29c. License number

000

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 2008 Brayden Hurley Hatchett 21 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death **Examiner** N/A The Johns Hopkins Hospital Baltimore City 8. Date of Birth (Month, Day, Year) 9/29/2008 Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5 Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 🔀 M 2 🗆 F Months Days 22 Hours Maryland 214-83-7297 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 28a-f show the Medical Examiner must be notified at 1 ¥ Yes 2 □ No Director N/A Baltimore 10f. Zip-Code 10g. Citizen of What Country? 10e. Street and Number USA 21230 29 E. Henrietta Street "natural", or items 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: þ 3 Widowed 4 Divorced White Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event \*\*\*\*. College (1-4 or 5+) Elementary/Secondary (0-12) N/A 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Whitney Brueckner Justin Hatchett ဂ္ 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Whitney Hatchett / Mother 29 E. Henrietta Street Baltimore, MD 21230 20c. Location - City or Town, State 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State Dulaney Valley Mem. 10/25/2008 Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Towson, Maryland 21204 Telle Ruck Towson Funeral Home, Inc. 1050 York Road 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Sc15.5

Due (or as a consequence of): **Physician** disease or condition resulting in death) /Medical **Examiner** enterocolitis Neurotzina Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Dua to for as a nonsciousince of Exami certificate be executed burial-tran and resulting in death) Last Due to (or as a consequence of) Box 68760,c ding physician Physician/Medical the as IF FEMALE: asn 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy Live birth 2 Fetal death in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 No P.O. 9 Unknown 9 Unknown the þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ filled in by the funeral director, page 2 should be 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? has 2 □ No 1 Tyes certificate Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) Hospital: 1 ☑ Inpatient 2 ER/Outpatient 3 DOA ပ္ this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Mannér of Death 28b. Time of 28c. Injury at Work? Certification: I or Attending Fafter death. Director: After 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 4 Homicide Hospital 24 hours a To the Hospital within 24 hours a To the Funeral C completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DO0 64 659 12008 IN who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person Pay 600 North Wolfe St, Baltimore, MD, 21287 Kurlen TON WU 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

24

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Item 26 per verb., 9884, 10/24/08dhb.

Certificate of Death

Bed, No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** onnson owowo 5:50 PM 0 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Sommer tom Good BALTIMORE BALTIMORE DITON If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, **3** - 17 -5. Social Security Number Birthplace (State or Foreign Country) (In yrs. last birthday) **Funeral** 1-56-9138 1**X**M 2□F Months Days Hours Min. 95 **Director** laryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinas mans the matter. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 res 2 No timore 10e reet and Number 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗙 No ρ If Yes, Give Year or Dates: Specify. 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) state c 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Be ဂ္ mnieli nı 19a. Informant's Name/Relationship (Type, Print) (Wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CaylorD-Ohason 20a. Method of Disposition 20b. Place of Disposition (Namcemetery, crematory or off Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee wes 23a. Part1. Enter the Isease, or complications that caused the death. Do not ente shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** o candia disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner weeks or Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) the death certificate be executed burial-transi and a Due to (or as a consequence of) P.O. Box 68760. cate has been signed by the attending physician page 2 should be detached for use as the burial IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 Yes 2 No 3 Probably 4 Unknown Completed this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an was a... autopsy performed? Ves 2 MNo 1 ☐ Yes 2 No 1 ☐ Yes Hospital or Attending Physician: completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 ☐ Pending investigation Iniury death. 1 ☐ Yes 2 ☐ No s after death 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) och Raven Blvd., Baltmore, MD 21239 Howk 560 Richard

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

OCT 24

32. Registrar's Signature

Registrar

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1	For State Registrar	State of Marylan		tificate of i		-	Reg. No.	008	33927		
Physi	icial		1. Decedent's Name (First, Middle, Las	YAH L				Date of Dea     Month	ath Day	Year	3. Time of Death		
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Exam	nine	'	4a. Facility Name (If not institution, give				r Location of Death		4c. Col	unty of Death			
Funera	al		5. Social Security Number 6. Se	7. Age (In yrs.	last birthday)				h Voor	9. Birth	place (State or Foreign intry)		
Directo	_		212–22–5006	⊒M 2XX F 86	5 Yrs.	Months Days	Hours Min.	May 16		2 Nor	th Carolina		
pu »		- 1	Usual Residence of Decedent  10a. State 10b. County	10c Cit	y, Town or Lo	cation			-		10d. Inside City Limits		
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rylc	ŀ	0	John Kennedy  19a, Informant's Name/Relationship (7)	Ivon Print)	10h Mailir	ng Address (Street	L			wn State 7	in Code)		
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Page nent c			1	Removal from State	rdens (	)f Faith	Com CCC	ober 27, 2008	Rose	edale,	Maryland		
Dallimore, Interpretation 2 12 13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantment must be realthed at	ouce		21. Signature of Funeral Service Licen	ennolle	22	Name and Addre Connelly 7110 Soll	ess of Facility Funeral	Home Of	Dunda.	lk, B.	<sup>A</sup> <b>ว</b> ่1222		
			23a. Part 1. Enter the disease, a complications that caused the death. Do not enter the mode of dying, such as cardiac or resshock, or heart failure.							in na.	Approximate Interval Between		
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/Medica	-		resulting in death)	Due to (or as a conseq	-	, , , , , , ,							
Examine	•	_	Sequentially list conditions,								4 DAYS		
111/2		in a	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	- Day to (or as a conseq	district cry.								
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HECORDS, he law requires t e has been signe tge 2 should be o		Completed		*				24a. Was		4b. Were au	topsy findings available completion of cause of		
The The page		Con						perfo 1 □ Yes	rmed? 2 ₩No	death? 1 □ Yes	2 □No		
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Phys rthis ral dir		e E							Home 5 ☐ Residence 6 ☐ Other (Specify)  28d. Describe how injury occurred				
Attending r death. ector: After by the fune									200. Describe now injury occurred				
LIVISION Of VITAI RECORDS, P.O. BOX To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use:		Certification: To	3 ☐ Suicide 4 ☐ Homicide  3 ☐ Suicide 4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide					28f. Location (Street and Number or Rural Route Number, City or Town, State)					
To the Hospital or within 24 hours afte To the Funeral Dir. completely filled in I									cause(s) ar	nd manner as	s stated.		
n 24 h n 24 h ne Fur oletely		Medical	(Check only 2 Medical Examone)	niner: On the basis of examination and manner stated.	ation and/or ir	nvestigation, in my	opinion, death occ	curred at the time					
To the comp		Š	29b. Signature and title of certifier 29c. License number						29d. Date s	igned (Monti	h, Day, Year)		
			Canasa Malkerbulla RES-000						CCTOB	ER 24	1,3cc8		
9.			30. Name and address of person who				AVENISE	- RA	THINDS	Dun	21334		
	Stat	e_	VANCESSA WALKER 31. Date filed (Month, Day, Year)	32 Registrar's Sign	ature	CAS JERN	0 1100 000	1240	I IPICILI	1110			
Regi			OCT 24 2	008	13. All	DOMEST.							

DHMH 17 Rev 1/2001

			For State Registrar	State of M		/ Depa		of H	lealth a				-	8 33928	
	D)		1. Decedent's Name (First, Middle,	Last)							2. Date of De	ath Day	Yea	3. Time of Death	
	Physician /Medical		Robert	Kau	Kaufmann						October 22			6:15 p <sup>M</sup>	
	Examin		4a. Facility Name (If not institution,				4b. City, 7		Location of				County of De		
			Genesis Elder						ndalk				Baltir		
	Funeral		5. Social Security Number 213–32–6805	. Sex	ge <i>(In yrs. l</i> a <i>s</i> <b>76</b>	st <i>birthday)</i> Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Bird (Month, Da June 20	th v, <i>Year</i> )		irthplace (State or Foreign Country)	
	Director		Usual Residence of Decedent		70 110.						June 26, 1932 Ma			aryland	
	/land		10a. State 10b. County		10c. City,									10d. Inside City Limits	
	Many P-f sh	햣	Md. Bal	timore			Dunda.	lk						1 ☐ Yes 2X No	
	or 28	ire	10e. Street and Number				10f. Zip	Code				10g. Citiz	en of What (	Country?	
	th wit	<b>Funeral Director</b>	6713 Thruway				:	2122	2				USA		
	ems	ine.	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S.	13.	Was Decede	ent of Hi ify Cuba	ispanic Ori n, Mexicar	igin? (Spo	ecify Yes or No Rican, etc.)	- 1	4. Race - Ar Black, Wh	nerican Indian,	
36	or It	by Fu	1 ☐ Never Married 2 ☐ Marrie	If Yes, Give	No		1 □Yes 2		Specify:					White	
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show that the M-dical Exat, for rout by notified at	g p	3₺ Widowed 4 Divorced	Year or Dates:		16a Daga	dent's Usua	I Cooun	otion			16b. Kind of Business/Industry			
15	n 72 "nal	Completed	15. Decedent's (Specify only highest	grade completed)		(Give	kind of worl	k done a	durina mos	t of worki	king			S/ITIOUSTI y	
212	withi	E	Elementary/Secondary (0-12)  8 Years	College (1-4or	5+)		Deli					Bl	Blueprints		
D	other ent,	Be C	17. Father's Name (First, Middle, La	ist)					18. Mothe	er's Name	(First, Middle,	Maiden S	Gurname)		
Maryland	2 should be filed v n and Mental Hygie is marked other t raumatic event, th	10 E	Frederick J.	Kaufmann					Z	Anna	Probst				
ary	shot s ma		19a. Informant's Name/Relationship			19b. Mailir	ng Address	(Street a	and Numbe	er or Rur	al Route Numb	er, City or	Town, State	, Zip Code)	
	1 and 2 Health a tem 27 is		Melvin Ichnoski	Brother						Balt	cimore M	Maryl	and 2°	1222	
ore	S = = 0		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	□ Removal from State	20b. Plac	ce of Dispo netery, crer	sition (Nam natory or ot	e of her place	e) (		per 24,			or Town, State	
ij	Pages thent of the tant: If ite		4 □ Donation 5 □ Other (Spe	cify)	Bay		Crema			200		Ва	ltimoı	ce, MD.	
Baltimore,	permit. Page Department o Important: If any Injury or once.		21. Signature of Funeral Service Li	Conul	lle		Name and Onnel				me Of I	Sunda Sunda	łk. Ro	A. 21222	
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate Interval Between												
* 164	Physician /Medical Examiner		Immediate Cause (Final disease or condition ATRIAL FIBRILLATION												
			resulting in death)  Due to (or as a consequence of):												
		<u>_</u>	Sequentially list conditions,	b. MONE	NIA	A									
	ted	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):												
	ite be executed ysician and ie burial-transit	Examiner													
760,	e be e siciar buria	cal	LONGESTIVE HEART FAILINRE												
89	ifficat g phy as the			- w. W. 4 4 C							, , , , ,				
Вох	leath certificate t attending physik I for use as the b	<b>N</b>	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom			7 = 4 - 4 - 4	25.36				2	3d. Date of o	delivery	
B	deat ne att	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth			☐ Ectopic pr ☐ Other (spe		у				Month	Day Year	
P.0.	Phystclan: The law requires that the death certifica this certificate has been signed by the attending phrai director, page 2 should be detached for use as the	Physician/Med	9 Unknown												
Ś	w requires that s been signed b should be deta									23e. Did tobacco use contril			/		
ord	een s ould	ted	HYPERTEN	5/0/							1 🗆 `	Yes 2L	] No 3□	Probably 4 Unknown	
of Vital Records,	law r las be	Completed by									24a. Was an autopsy autopsy prior to comple			autopsy findings available completion of cause of	
H	scrificate has b irector, page 2 sl	Con									perfo 1 □ Yes	performed? death?			
/ita	clan: ertifi	Be	25. Was case referred to medical examiner?					1		Deat	h (Check only o	ne)			
of )	Physic this c	은	1 Yes 2 D No		ient 2 EF				4 M Ni		me 5 Resi			pecify)	
'n	ing F	ion	27. Manner of Death 1 ☐ Matural 5 ☐ Pending	28a. Date of In (Month, D	ay, Year)	8b. Time o Injury	M 28	Bc. Injury Work			28d. Describe	how injury	occurred		
isi	death death stor: / the	icat	2 Accident investiga 3 ☐ Suicide 6 ☐ Could no	t be	iury - At hom	e farm str			Yes 2 🗆		28f Location /	Street and	Numberor	Qural Pouta Number	
Division	lor A after Direc Jin by	Certification:	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Information of City or Town, State)							nurai noute ivaniber,					
	To the Hospital or Attending Phys within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral dir	Medical C		Physician: To the best caminer: On the basis and manners	of examinatio										
	To the within 2 To the complete	Me	29b. Signature and title of certifier				29c.	. License	e number					nth, Day, Year)	
	->-0		30. Native and address of person who completed cause of death (Item 23a) (Type, Print)  San Walle 10 Tulke 2 Mayiel Place Dundark MD 2/2								-08				
	1		30. Name and address of person w	no completed cause of	death (Item 2	3a) (Type,	Print)	. 1	1		A	10			
			Sanna 10	Tulle	21	ya	Jiel	- 1	160	2	Dun	dal	KM	1 21222	
	Sta		31. Date filed (Month, Day, Year)	32 Regis	rar's Signatu	re '	and the								
	Registr	-	OCT 2.4.2	008		A.A.	Alas								
DHI	MH 17 Rev 1/2	001		F64.		(3)									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) <sup>D</sup>21, October 2008 10:05PM **Physician** William J. Kotansky /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Baltimore 21 Placid Woods Court Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 14, 1958 7. Age (In yrs. last birthday) Social Security Number 219-60-9819 Funeral Days Hours Months 1 XM 2 □ F 50 Maryland Director Usual Residence of Decedent should be filed within 72 hours after death with the Maryland of Mental Hygiene.
marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10h Count 10c. City, Town or Location 10a State ? is marked other than "natural", or items 23a or 28a-f show traumatic event, the Hadlen Exx. inv. must be notified at 1 □Yes 2√□No Funeral Director Baltimore Baltimore MD 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number United States 21234 21 Placid Woods Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 🔀 Married Saltimore, Maryland 21215-0036 1 ∐Yes 2 XNo Specify: White Specify. ş 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Zurich Financial Lawyer 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) h and Mental F is marked ot Be Katherine G. Imperatore Lawrence L. Kotansky ဂ္ Pages 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) of Health a Placid Woods Court, Baltimore, MD 21234 Sara E. Kotansky - wife other Department of Healt Important: If item 2 any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place)

Evans Funeral Chapel & Cremation Services —Belair 10/23/2008 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, Maryland 22. Name and Address of Facility

Vans Funeral Chapel & Cremation Services 8800 Harford Road, Parkville, Maryland 21234 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final RUS Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consciousnes offi Examiner death certificate be executed physician and the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 □ Yes 2 □ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) P.0. 9 Unknown ģ 23e Did tobacco use contribute to the cause of death? signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performe 1∐Yes 2≅No 2-No 1 □Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide ō Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie ed cause of death (Item 23a) (Type, Print) 30. Name and address of person who comple HBVM < BALTIMOR, MP

Registrar DHMH 17 Rev 1/2001

State

4940

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 1 0 Month 2008<sup>ear</sup> 22 12:00 Krasniewski Mary Philomena /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Hillcrest Baltimore Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Days Min. Maryland 1 □ M 2 🕇 F 91 215-09-9438 Director 4-9-1917 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f sh Examinar must be notified 1 ☐ Yes 2X No Director Baltimore Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with t 2603 Hillcrest Ave. 21234 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or ite 1 Never Married 2 Married altimore, Maryland 21215-0036 "natural", or 1 ☐Yes 2 No Specify. Specify: 3 → Widowed 4 □ Divorced White event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nicholas Delaro Rose Daulerio ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas Billings -Son 7509 Park Drive Baltimore Md. 21234 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1 Department of H Important: If Ite any Injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Moreland Memorial Park 10-24-2008 Baltimore 22. Name and Address of Facility Leonard J. Ruck Funeral Home Inc. 21. Signature of Funeral Service Licenses 5305 Harford Rd. Baltimore,Md. 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) homi **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division of Vital Records. P.O. Box 68760. attending physician for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) been signed by the should be detached 9 Unknown 9 I Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown After this certificate has been funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation ours after death.
neral Director: Al 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral 29a. Certifier Manager of the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) and title of certifier 29c. License number

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

			State of Maryla	and / Department		lental Hygi	ene2008	33931
			Registrar	Certificate	or Death		g. No.	0 Time of Death
ш	Physicia	an	1. Decedent's Name (First, Middle, Last)  Curtis R. Krenzer			2. Date of Death Month	Day Year	3. Time of Death 3:50 PM
4	/Medic	al			wn, or Location of Death	10	2/ 2008 4c. County of Deat	
	Examin	er	4a. Facility Name (If not institution, give street and number)					
	Comment		Baltimore Washington Med 5. Social Security Number 6. Sex 7. Age (In y.	rs. last birthday) If Under 1		8. Date of Birth	Anne A	place (State or Foreign
ь	Funeral Director		216-14-6973   1MM 2   F   85	Yrs. Months [	Days Hours Min.	(Month, Day,		ryland
	ס		Usual Residence of Decedent					
	rylan show	<b>&gt;-</b>	10a. State 10b. County 10c.	City, Town or Location				10d. Inside City Limits 1 X Yes 2 □ No
	e Ma Ba-f s	Director	MD E	Baltimore				•
	or 2	Dire	10e. Street and Number	10f. Zip C		10	g. Citizen of What Co	untry?
	ath w	Funeral	534 Maude Avenue		.225	ifVN	U.S.A.	vices Indian
	er de item	nn:	11. Marital Status 1 □ Never Married 2 Married 1 □ Never Married 2 Married 1 □ Never Married 2 Married	943	nt of Hispanic Origin? (Sp Cuban, Mexican, Puerto	Rican, etc.)	14. Race - Ame Black, White	
36	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show the field Exemiter must be redified at	by F	If Yes Give	945 1 □Yes 21	No Specify:		Specify: W	hite
21215-0036	2 hou	peq	15. Decedent's Education	16a. Decedent's Usual (	Occupation		6b. Kind of Business/	ndustry
215	hin 7%	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work life. DO NOT use	done during most of work retired)	ang		
21	d with	Š	7	Diesel	Mechanic		Truckin	g
pu	should be filed within 72 hours after deal and Mental Hygiene. marked other than "natural", or items imatic event, it all added to the manatic event, it all added to the manatic event.	Be (	17. Father's Name (First, Middle, Last)			e (First, Middle, Mi		
yla	should band Ment s marked umatic e	ဥ	Elmer Martin Krenzer			May Gi		
Maryland	2 sho n and is ma		19a. Informant's Name/Relationship (Type. Print)	,	Street and Number or Ru			
	ges 1 and 2 should be filed within 72 hours after death with the Marylan nt of Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, If a Nedical Examination and the confilled at		Helen Krenzer - Wife	534 Maude		timore,	MD 212 Oc. Location - City or	
Baltimore,	Pages 'nent of Hant: If Ite		1 Burial 2 Li Cremation 3 Li Hemoval from State	D. Place of Disposition (Name cemetery, crematory or othe			•	
Ħ	permit. Pag Department Important: I any injury o	l in		len Haven M	Address of Essility		Glen Burr	
Bai	permit. Pages 1 and 3 Department of Health Important: If Item 27 any injury or other tr once.	, ,	21. Signature of Funeral Service Licensee		GJ		Funeral	Home, PA
			23a. Part 1. Enter the disease, or complications that caused the de		viera Dr of dving, such as cardiac			21122 Approximate
4	<b>.</b>	7 84	shock, or heart failure. List only one cause on each line. Immediate Cause (Final	l	+/	, ,		Interval Between Onset and Death
	Physician /Medical Examiner		disease or condition resulting in death)  a. Due to (or as a cons	omyofa	INY			syears
4			Carro		eroscler	05/5		royears'
Į.		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.		010 7000			
K	cuted nd ransit	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events  c.	er tension			P.	Me years'
0,	e exe ian ar ırial-t	Ex	resulting in death) Last Due to (or as a cons	sequence of):				
8760,	cate be executed ohysician and the burial-transit	dical	d					
9		Mec	IF FEMALE:					
Вох	eath certific attending p	ian/	23b. Was decedent pregnant in the past 12 mogulas?  23c. If yes, outcome of pregnant in the past 12 mogulas?	etal death 3 Dectopic pre-			23d. Date of del Month	ivery Day Year
0	he de	Physician/Me	1 ☐ Yes 2 ☑ No 4 ☐ Pregnant at time 9 ☐ Unknown	of death 5 ☐ Other (spec	:iry)			
σ.	that t ed by detac	Ph.	Part II. Other significant conditions contributing to death but not	resulting in the underlying cau	se given in Part I.	23e. Did toba	acco use contribute to	the cause of death?
sp	uires sign Id be	Completed by	Chronic Obstruction	ve Pulmor	rary Des	EASC 1 ZVes	s 2 □ No 3 □ Pr	obably 4 🗆 Unknown
000	w req	lete	Obmany Atrial F	2: bx: 1/0x	More	24a. Was an	24b. Were au	topsy findings available
Re	he la e has	шc		- William	,	autopsy perform	prior to death?	completion of cause of
tal	an: T tifical tor, pa		25. Was case referred to medical		26. Place of Dea	1 ☐Yes 2, th (Check only one	•	2 🗆 No
<u>&gt;</u>	ysicia is cer direct	o Be	examiner? 1 ☐ Yes 2 ☑ No  Hospital: 1 ☐ Inpatient 2	ER/Outpatient 3 □ DOA	Othor		nce 6 ☐ Other (Spe	cifv)
Division of Vital Records,	ng Ph terth neral	Certification: To	27. Manner of Death 1 ☑ Natural 5 ☐ Pending (Month, Day, Year	28b. Time of 28c	. Injury at Work?	28d. Describe how	w injury occurred	
Ö	endir sath. or; Af he fui	atic	2 Accident investigation	M	1 ☐Yes 2 ☐No			
i≥i	r Atto	tific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - A building, etc. (Special Could not be determined 28e. Place of Injury - A building, etc. (Special Could not be determined 28e. Place of Injury - A building, etc. (Special Could not be determined 28e. Place of Injury - A building, etc. (Special Could not be determined 28e. Place of Injury - A building, etc. (Special Could not be determined 28e. Place of Injury - A building, etc. (Special Could not be determined 28e. Place of Injury - A building, etc. (Special Could not be determined 28e. Place of Injury - A building, etc. (Special Could not be determined 28e. Place of Injury - A building, etc. (Special Could not be determined 28e. Place of Injury - A building, etc. (Special Could not be determined 28e. Place of Injury - A building, etc. (Special Could not be determined 28e. Place of Injury - A building, etc. (Special Could not be determined 28e. Place of Injury - A building, etc. (Special Could not be determined 28e. Place of Injury - A building, etc. (Special Could not be determined 28e. Place of Injury - A building, etc. (Special Could not be determined 28e. Place of Injury - A building, etc. (Special Could not be determined 28e. Place of Injury - A building, etc. (Special Could not be determined 28e. Place of Injury - A building, etc. (Special Could not be determined 28e. Place of Injury - A building, etc. (Special Could not be determined 28e. Place of Injury - A building, etc. (Special Could not be determined 28e. Place of Injury - A building, etc. (Special Could not be determined 28e. Place of Injury - A building, etc. (Special Could not be determined 28e. Place of Injury - A building, etc. (Special Could not be determined 28e. Place of Injury - A building, etc. (Special Could not be determined 28e. Place of Injury - A building, etc. (Special Could not be determined 28e. Place of Injury - A building, etc. (Special Could not be determined 28e. Place of Injury - A building, etc. (Special Could not be determined 28e. Place of Injury - A building,	t home, farm, street, factory, o ecify)	office	28f. Location (Stre City or Town,	eet and Number or Ro State)	ıral Route Number,
	urs af							
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending I completely filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier (Check only one) 1 1					
	o the ithin o the omple	Mec	29b. Signature and title of certifier	29c. I	icense number	29	d. Date signed (Mont	h, Day, Year)
	⊢ <b>≯</b> ⊢ ŏ		I Colis a Coston	7 1	01459		Oct 1.2.	2008
	11		30. Name and address of person who completed cause of death (I	Item 23a) (Type, Print)	1	1 ^	00,000)	2008 ld 21216
	511		Colum C. Carter	4710 Per	ining for	Are. B	alta, n	10/21216
	Sta	te	31. Date filed (Month, Day, Year) 22. Registrar's Signary	gnature	0"			
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DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Iviary		tificate of			g. No.	3 33933		
	Physici	an	1. Decedent's Name (First, Middle, Las	t)	LEVIT	T		2. Date of Death		3. Time of Death 7:40 P M		
NG.	/Medi	cal	SELMÁ 4a. Facility Name (If not institution, give	street and number)	LEVII		r Location of Death	OCTOBER	4c. County of Dea			
١.,	Examir	ier	4730 ATRIUM CT., #			OWING	GS MILLS		BALTIN			
	Funeral Director		210-48-1328	ex □ M 2 A F 7. Age (In 93	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 08/11/19	Year) 9. Bir Co 15	thplace (State or Foreign buntry)		
	/land		Usual Residence of Decedent  10a. State 10b. County	100	c. City, Town or Lo	cation				10d. Inside City Limits		
	e Mary 3a-f sh	ctor	MD BALTIMO	DRE	OWI	NGS MILLS	S			1 ☐ Yes 2 🚮 No		
	with th	Funeral Director	10e. Street and Number	4402		10f. Zip Code 211	1 7	10	g. Citizen of What Co USA	ountry?		
	ms 23	nera	4730 ATRIUM CT.,	12. Was Decedent Ever	in U.S. 13. \		lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	14. Race - Ame			
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show amportant: If Item 27 Is marked other than "start and Item of Item Item Item Item Item Item Item Item		1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	Armed Forces? 1	I	ryes, specify Cuba	an, Mexican, Puerto  Specify:	Hican, etc.)	Black, Whit	e, etc. WHITE		
15-(	n 72 h " <b>natu</b> edical	olete	15. Decedent's Edi (Specify only highest grad	de com <i>pleted)</i>	16a. Deced	dent's Usual Occup kind of work done OO NOT use retired	pation during most of work d)	ing 1	6b. Kind of Business	/Industry		
212	d withi giene. er than	Completed by	Elementary/Secondary (0-12)	College (1-4or 5+)		WNER			GROCEF	RY		
Maryland	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, Item	To Be C	17. Father's Name (First, Middle, Last) JACOB		BL00M		18. Mother's Name S	e (First, Middle, M ARAH		OFFE		
/lar	2 shot and 1 ls ma	ľ	19a. Informant's Name/Relationship (7	,					City or Town, State,			
	1 and 2 Health tem 27 l		CAROLYN PRESSMAN  20a. Method of Disposition	•			ER DR., O		Oc. Location - City or	Town, State		
Baltimore,	permit. Pages 1 Department of the Important: If ite any Injury or ot once.		1 🖾 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other <i>(Specify</i>	) [	ARLEMAN CON	GREGATIO	N = 10/2		BALTIMORE			
Ba	perm Depa Impo any l		21. Signature of Funeral Service Licens	see					SON & BROS PIKESVILLE	s., INC. E, MD 21208		
	Physician	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a										
J.	/Medical Examiner	resulting in death)  Due to (or as a consequence of):										
7	led sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a co	nsequence of):							
,	e be executed sician and burial-transit	Exan	that initiated events resulting in death) Last	c. Due to (or as a co	nsequence of):							
68760,	icate be physicia the bur	Aedical	(	d								
	certific ding p se as t	/Mec	IF FEMALE:	23c. If yes, outcome of pr	regnancy				00 1 5 1 1 1	Parama		
.O. Box	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit	Physician/	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	1  Live birth 2  4 Pregnant at time 9 Unknown	Fetal death 3 [	Ectopic pregnand Other (specify)	cy		23d. Date of de Month	Day Year		
s, P.	ires that signed to	by Pt	Part II. Other significant conditions co	ontributing to death but no	t resulting in the ur	nderlying cause giv	en in Part I.			o the cause of death?		
ord	w require been si should b			<u></u>				1 □ Ye	s 2 <b>6</b> No 3 ☐ F	robably 4 Unknown		
Records,	The law cate has t	Completed		<u></u>			-	24a. Was ar autopsy perform	prior to death?	utopsy findings available completion of cause of		
of Vital	ician: Th certificate ector, pag	Be Co	25. Was case referred to medical				26. Place of Deat	1 ☐ Yes 2 th (Check only one		s 2 No		
of V	Physicia this cerral direct	မ	IL les ZINO		2 ER/Outpatier		4 Li Nursing Ho		nce 6 ☐ Other (Spe	ecify)		
on (	ing After	tion:	27. Manner of Death  1   Matural  5 □ Pending investigation	28a. Date of Injury (Month, Day, Ye	ar) 28b. Time of Injury	Wor	ryat k?  Yes 2 □ No	28d. Describe ho	w injury occurred			
Division	or Attending after death. Director: After in by the fune	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, str pecify)			28f. Location (Str City or Town	eet and Number or F State)	ural Route Number,		
_	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fo	Medical Co		ysician: To the best of m hiner: On the basis of exa and manner stated.								
	To the within 2 To the complete	Me	29b. Signature and the of certifier	11	0 /01	29c, Licens	se number	25	d. Date signed (Mon	th, Day, Year)		
	d		30. Name and address of person who	completed sause of death	(Item 23a) (Type,	Print)	0061		2 1	2008		
	1		Lowrence So	COMON Mi	2700	Quar	og Lake	ich I	als M	y2007		
e	Sta Regist		31. Date filed (Month, Day, Year)  OCT 2 4 2008	32. Registrar's	Signature		V					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland Department of Health and Mental Hygiene Z3art1,25,27,28a-f per me, g884,10/24/08dhb Red, No. 1 - For State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Oct 7, 2008 5:38 P M Helen Luparelli /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Baltimore Washington Medical Center Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Months Min. 1 M 2 XX Feb 17, 1917 Director 91 MA 215.07.8871 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County if than "natural", or items 23a or 28a-f show 1 ☐ Yes XX No Director Anne Arundel Glen Burnie 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 21060 USA 2 Stevens Rd Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1XX Never Married 2 ☐ Married 1 ☐ Yes XXX No Specify: Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 2121 filed within is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Health and Mental Hygiene. 12 Secretary USG&G Itimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be မ Trifim Goodzuk Mary Kirchner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health a
Important: If item 27 is
any Injury or other trau 2 Stevens Rd, Glen Burnie, MD 21060 John Ronald Decker Nephew 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date XX Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Cemetery Oct 10, 2008 Glen Burnie, MD 4 ☐ Donation 5 Other (Specify) 21. Signal re - Funer I S. rvi e Li Name and Address of Facility Bal Fink Funeral Home, P.A. uregory Fink M01148 426 Crain Hwy S., Glen Burnie, MD 21061 23a. Part 1 Enter the disease, of conshock, or heart failure. List only Approximate Interval Between Onset and Death com ons that caused the do th. Do not ter the mode of dying, such as cardiac or respiratory arrest Immediate Couse (Final disease or condition resulting in death) **Physician** /Medical ma Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a dins Examiner sician and burial-tran Jath M nhs insequence of) attending physician for use as the buria Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 mon Month Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 3 Pobably 4 Unknown 1 ☐ Yes 2 ☐ No Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an The law certificate has , page 2 autopsy performed 2/1100 Division of Vital 1 □Yes 1 ☐ Yes Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) miner? examiner? 1 Yes 2 H Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? After 1 28d. Describe how injury occurred or Attending 1 Accident 5 Pending investigation 10/05/2008 9:00 p.M death. 1 ☐ Yes 2 📉 No Subject fell. hours after death filled in by the 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2 Stevens Road, determined 4 Homicide Home Glen Burnie,MD Hospital 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the dasis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manyler stated. To the within 2 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 108 0

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

24

82. Regist/ar's Signature

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** October 19 ay 2008 ar LEWI1 9:00em 1500 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 101 N. Denison St. Baltimore N/A 8. Date of Birth (Month, Day, Year) 9-24-1951 5. Social Security Number 6 Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔀 F Months Hours Min 57 Yrs. Maryland 218-58-8201 **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits other traumatic event, the Medical Examinar must be multihed at Director 1 Des 2 □ No Md. N/A Baltimore permit. Pages 1 and 2 should be filed within 72 hours after death with the N Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature" any injury or other traumating. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 101 N. Denison St. 21207 Funeral USA 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 No ģ Specify: Black 3 X Widowed 4 □ Divorced Be Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clerk IRS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Clark Lois E. James ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Derek Tucker(Son) 19 Garobe Ct. Baltimore, Maryland 21207 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 10-28-2008 20c. Location - City or Town, State 1X Burial 2 Crematio 3 Removal from State Owings Mills, Maryland Garrison Forest Veterans 4 Donation 5 ☐ Other (Specify) 21. Signature o Funcial Service lice see Jonathan D. Hibner Name and Address of Facility Redd Funeral Service 1721-27 N. Monroe St. Baltimore, Maryland 21217 23a. P rt1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, so to to heart failure. List only one cause on each line. Imm Idia\* Cause (Final dise see r condition resulting in death) Onset and Death ARDEAL **Physician** /Medical Due to (or as a consequence of): Examiner FATLURG HEART Sequentially list conditions, if any leading to him clast cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Completed by Physician/Medical Examiner Due to (or as a consequence of) CPTDENTX IF FEMALE: NIA 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 C Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 9 Unknown 5 Other (specify) 1 ☐ Yes 2 X No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? STENOSED 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐Yes 2 ☐No 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. injury at Work? 28d. Describe how injury occurred 5 Pending investigation

To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Division of Vital Records, P.O. Box 68760, attending physician for use as the burial been signed by the should be detached this certificate has al director, page 2 : nours after death.

neral Director: After this
y filled in by the funeral di within 24 hours a

To the Funeral C

completely filled

or Items 23a or 28a-f show

State Registrar W. REDWUIY

Registrar's Signature

and manner stated

3808

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year) 10-20-08

Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

51. 5-14,

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

31. Date filed (Month, Day, Year)

2 Accident

3 Suicide

29a. Certifier (Check only one)

4 Homicide

6 ☐ Could not be



# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				1 - For State Registrar		Otate of	iviai yia		•	ficate of	Death	Wentain	Reg. N	201	96	33936
		Physici	an	1. Decedent's Nam	e (First, Middle,	Last)						2. Date of I		ay	Year	3. Time of Death
		/Medic		Donal	d B. Ma	anuel						Octob	er	19,	2008	1533 <sup>™</sup>
	1	Examir	er	4a. Facility Name (/					4	lb. City, Town,	or Location of Dea	ath	4	c. County		
				Hartfor			spita 7. Age (In vr				de Gra		): mblo	Hart		
	н	Funeral		5. Social Security N		5. Sex 1 🛣 M 2 🗆 F	3 . ( )			Months Days		n. (Month, L	Ја <i>у, Үе</i> а		9. Birthpi Coun	ace (State or Foreign try)
		Director		196-24- Usual Residence of			7.5	)				June	5,1	933 1	enn	sylvania
		land ow tt		10a. State	10b. County		10c. 0	City, Town	or Locat	tion					10	0d. Inside City Limits
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		with the Marylan a or 28a-f show be notified at	rec	10e. Street and Nu		Sid				10f. Zip Code			10g. C	Citizen of W	hat Coun	try?
		3a ol	Funeral Director	326 Cho.	ice St	reet				2	21014			US	SA	
		ours after death w ral", or items 23a Examiner must b	ner	11. Marital Status		12. Was Dece Armed For			13. Wa	s Decedent of I	Hispanic Origin? can, Mexican, Pu	(Specify Yes or N	10-			an Indian,
	9	after or ite mine		1 Never Marr			<sup>2</sup> □No 1	L951	_	es, specify Cut ¶Yes 2□ No		eno nican, etc.)			, White,	
	03	filed within 72 hours after death with the Maryland Hygiene. yther than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	d by	3 Widowed	4 Divorced	Year or Da	ites:	L954	1 12	1103 ZLI140	opedity.			эреспу.	Blac	:K
	5-0	72 hours "natural"; dical Exe	Completed	(Spec	15. Decedent's cify only highest	Education grade completed)		16a. I	Deceder Give kir	nt's Usual Occu and of work done	pation during most of wed)	orking	16b.	Kind of Bu	siness/Ind	lustry
	21	d within 7 giene. r than "n the Medi	Ig III	Elementary/Seco	ndary (0-12)	College (1	-4or 5+)				ed)					
	2	led w tygie her ti nt, th	වී	17. Father's Name	/First Middle L	2001		1	Sal	esman	19 Matharia N	ame (First, Midd	lo Maide		vat	e
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ب		Dhysisian		Immediate Lause	Final	nly one cause on e	ach line.	-1		- I	- 1	71	- 1	Landillo		Onset and Death
		Physician /Medical		disease or condition resulting in death)	n	a. Due to (	nd s	> 100	e	Chr	onic	105160	101	Ve-	-	
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3	S	Attending r death. ector: After	icat	2 ☐ Accident 3 ☐ Suicide	6 ☐ Could no	t be	of injury - At	home, farr	n. street	t, factory, office		28f Location	(Street	and Numbe	ar or Rum	l Route Number,
3	Division	after Dire	ertit	4 Homicide	determin	ea buildii	ng, etc. (Spe	cify)	.,	,,,		City or 7	own, Sta	ate)	J. 07 . 1010	
a note		Hospital 24 hours a Funeral I tely filled	C	29a. Certifier	1 Dertifying	Physician: To the	best of my k	nowledge,	death o	ccurred at the t	time, date and pla	ace, and due to the	ne cause	(s) and ma	nner as st	tated.
3		To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical Certification:	(Check only one)	2 Medical E	xaminer: On the ba and mann	asis of exami ner stated.	nation and	or inve	stigation, in my	opinion, death of	ccurred at the tim	ie, date a	and place, a	and due to	the cause(s)
		To the within 2 To the Comple	Me	29b. Signature and	title of certifier	1	10			29c. Licen	se number		29d. [	ate signed	(Month,	Day, Year)
					Nam	M			0	D10	1503		Do	taho	P 1	9.2008
		2		30. Name and add	ess of person w	ho completed caus	e of death (It	em 23a) (T	ype, Pri	int) D	2.4/ Ct	en +	X1	1	0	1
		5		Man	rel l	azati	5 n	12		8 4	100 511	reet	ND.	eras	en,	1 gryant
		Sta		31. Date filed (Mon	oth, Day, Year)	4 2008 b	e <b>gi</b> strar's Sig	nature	A	marks o					1	,
		Registr	ar		0016	I LUUW J	38 July 4 miles	100	A	The state of the s						

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State of Maryland / Department of Health and Mental Hygiene 2 0 0 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 5:00 A. M Hazel Clark Moore October 22, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 2307 Crest Road Baltimore City If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1 □ M 2√5/F 86 007-12-7437 8/27/1922 Director Maine Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits 10a. State 10b. County show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Oppertment of Health and Mental Hyglene. Included the state of the Inportant; I frem 27 is marked other than "natural", or items 23a or 28a-f show any injunt; If item 27 is marked other than "natural", or items 23a or 28a-f show any injunt; or other traumatic event, It a Maries I Examinar must be notified at 1 totes 2 □ No Director Baltimore Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States of America 2307 Crest Road 21209 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Mayes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 □Yes 2⊠No Specify: Specify: ģ white 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Recreation Nursing Home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Fernald Clark Claire Colbeth ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Claire L. Moore/ daughter 2307 Crest Road Baltimore, Maryland 21209 Baltimore, 20b. Place of Disposition (Name of cemetery, grematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State October 2008 Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Chapel- Bel Air Peaceful Alternatives Funeral & Cremation Ctr., P.A. 21. Signature of Futheral Service Licensee 2325 York Road Timonium, Maryland 21093 23a. Partif. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final metastic breat concer **Physician** 3 yrs disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed burial-transi and Due to (or as a consequence of) Box 68760, attending physician for use as the hurial Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☑ No Ö 9 D Unknown σ. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I page 2 s autopsy performed? certificate 2 3 No 1 ☐ Yes 2 No 1 ☐ Yes Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this Certification: To After this funeral of 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Division Hospital or Attending 1 Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier OH- MD October 23 2008 D40850 9x1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gumme Otteviano MD 9103 Bultimre MO 21237 Franklin · Br. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 2.4 2000 Registrar

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Please Type or Print in Black Indelible Ink. En	sure All Copies Are Legible.
State of Maryland / Department of Healtl	h and Mental Hygiene
Certificate of Deat	th Reg. No. 7 1 1 2
(First, Middle, Last)	2. Date of Death  Month  Pay  Year

			For State Registrar		State of Ma	aryland	-	artment of F rtificate of I		Mental H	ygie: Reg.			00000
				ne (First, Middle, La	st)		-			2. Date of D	eath	201	<del>) &amp;</del>	3. Time of Death
	Physici /Medi		Joseph J	J. Maisch	Jr					Month	ber	20th 2	ear <b>6</b> 8	10.35 PM
	Examir	ner		-	re street and number)			4b. City, Town, or		th		4c. County of		25
			5. Social Security N		BELAIR	e (In yrs. las	t hirthday)	If Under 1 Year	Air	8 Date of B	irth	HAR		
	Funeral Director		214-14-5 Usual Residence of	1887	M 2□ F	86	Yrs.	Months Days	Hours Min.		ay, Ye -19:	21	Coun	lace (State or Foreign try) MD
	aryland show	_	10a. State	10b. County		10c. City,	Town or Lo	cation					10	Od. Inside City Limits
	he Ma	ecto	MD	Harfor	rd	E	Bel A							1 □ Yes 21√2 No
	a or	흐	10e. Street and Nu	norton Rd				10f. Zip Code			10g.	Citizen of Wha	it Coun	try?
	ns 23	Funeral Director	11. Marital Status	iorton ka	12. Was Decedent I	Ever in U.S.	13. \	21015 Was Decedent of H	ispanic Origin? (5	Specify Yes or N	0-	USA 14. Race -	Americ	an Indian.
21215-0036	72 hours after death with the Maryland "natural", or items 23a or 28a-f show ideal Examiner must be notified at			ied 2 Married	Armed Forces? 1 ⊠Yes 2 □ N If Yes, Give Year or Dates:			Was Decedent of H fYes, specify Cuba I⊡Yes 2 ☑ No	Specify:	to Rican, etc.)		Black, Specify:		etc.
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2	filed withir Il Hygiene. other than rent, the M	ပိ	12	(First, Middle, Last)	}	J	Jet Pi	LIOT	18. Mother's Na	mo (Firet Middle	_		Lona	1 Guard
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Maryland	s 1 and 2 should be f Health and Mental tem 27 Is marked o	٦	19a. Informant's Na	ame/Relationship (	Type. Print)		19b. Mailin	g Address (Street				ty or Town, Sta	ate, Zip	Code)
	and 2 saith ar 27 is		Janice P	usey	(Daughter)		4336	Horner L	ane Be	lcamp,	MD	21017		·
ore	of He of He fiter		20a. Method of Dis		Removal from State	20b. Plac	ce of Disponetery, cren	sition (Name of natory or other plac		Date		. Location - Cit	y or To	wn, State
Ë	Pag Iment Iant: I			5 ☐ Other (Specif		1		Crematory	,	22-2008	В	altimo:	e,	MD
Baltimore,	permit. Pages 1 and 2.9 Department of Health a Important: If item 27 Is any Injury or other trau once.											Iome ID 2	of BelAir 1014	
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between
Immediate Cause (Final disease or condition resulting in death)   Immediate Cause (Final disease or condition resulting in death)   Immediate Cause (Final disease or condition resulting in death)   Immediate Cause (Final disease or condition resulting in death)   Immediate Cause (Final disease or condition resulting in death)   Immediate Cause (Final disease or condition resulting in death)   Immediate Cause (Final disease or condition resulting in death)   Immediate Cause (Final disease or condition resulting in death)   Immediate Cause (Final disease or condition resulting in death)   Immediate Cause (Final disease or condition resulting in death)   Immediate Cause (Final disease or condition resulting in death)   Immediate Cause (Final disease or condition resulting in death)   Immediate Cause (Final disease or condition resulting in death)   Immediate Cause (Final disease or condition resulting in death)   Immediate Cause (Final disease or condition resulting in death)   Immediate Cause (Final disease or condition resulting in death)   Immediate Cause (Final disease or condition resulting in death)   Immediate Cause (Final disease or condition resulting in death)   Immediate Cause (Final disease or condition resulting in death)   Immediate Cause (Final disease or condition resulting in death)   Immediate Cause (Final disease or condition resulting in death)   Immediate Cause (Final disease or condition resulting in death)   Immediate Cause (Final disease or condition resulting in death)   Immediate Cause (Final disease or condition resulting in death)   Immediate Cause (Final disease or condition resulting in death)   Immediate Cause (Final disease or condition resulting in death)   Immediate Cause (Final disease or condition resulting in death)   Immediate Cause (Final disease or condition resulting in death)   Immediate (Final													+	Onset and Death
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.O. Box	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 burins after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal de	eath 3	Ectopic pregnancy Other (specify)	/			23d. Date o Month		ry Day Year
<b>Q</b> .	s that ned b deta		Part II. Other signif	ficant conditions o	ontributing to death bu	ıt not resultir	ng in the ur	derlying cause give	en in Part I.	23e. Did	tobacc	co use contribu	te to th	e cause of death?
ğ	equires	ed b	DYSPHI	AGIA,	HYPERTEM	SION	HY	POTHYRO	DISM,	10	Yes	2 No 3	Prob	ably 4 Unknown
Records,	e law re has be ye 2 sho	Completed by	STROK	: E						24a. Was	s an opsy ormed	prio	r to con	osy findings available inpletion of cause of
a	n: Th ificate or, pag		25. Was case refer	rad to madical	_					1 □ Yes	2 🐼	No 1		2 □ No
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o o	g Phy ter thi teral o	ü	27. Manner of Deat	h	28a. Date of Injui	y 28	Bb. Time of	28c. Injury Work		28d. Describe			<i>Specity</i>	9
ior	endln ath. or: Aff	atio	1 ArNatural 2 ☐ Accident	5 Pending investigation	1	, rear)	Injury		r res 2 □ No					
Division	al or Att	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Inju building, etc	ry - At home . <i>(Specify)</i>	e, farm, stre	eet, factory, office		28f. Location City or To	(Street wn, St	and Number o	r Rurai	Route Number,
	ne Hospit n 24 hours ne Funera pletely fille	Medical (	29a. Certifier (Check only one)	1 ☐ Certifying Ph 2 ☐ Medical Exam	nysician: To the best on niner: On the basis of and manner sta	examination	edge, death n and/or inv	occurred at the tin restigation, in my o	ne, date and plac pinion, death occ	e, and due to the urred at the time	e cause e, date a	e(s) and mann and place, and	er as st due to	ated. the cause(s)
	To the To the Comp	M	29b. Signature and	title of certifier	7			29c. License				Date signed (A		
				Millig	uften 1	10		245	344		10	1221	20	of
	10		7		completed cause of de	eath (Item 23	3a) (Type, F	Print)						
		to	31. Date filed (Mont	F 11 - 1	JANI MI	r's Signature	225.	UNIONI	ANE HI	AVRIE D	E 9	RACE	140	21078
	Registr	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  SURESH DHANTANI MD, 6225. UNION AVE HAVRIE DE GRACE, MD 2/078  State strar  OCT 2 4 2008												

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Da **Physician** October Kathleen Ann McLaughlin 2008 /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner BALTIMORE WASHINGTON MEDICAL CENTER Glen Burnie Anne Arundel 8. Date of Birth (Month, Day, Year) Feb 28, 1940 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex **Funeral** Days Min Months Hours 1 □ M 2 🖾 💢 F 68 Director 124-30-8457 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits death with the Maryland 10a State 10h County 28a-f show traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes XX No MD Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a or 21061 USA 1014 Somerset Dr Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2★★No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 1 ☐ Yes 2 ★3
If Yes, Give
Year or Dates: 1 Never Married 2 KMarried Maryland 21215-0036 1 ☐ Yes 2 🖾 XNo Specify Specify. 2 3 ☐ Widowed 4 ☐ Divorced White "natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Title Clerk 12 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Catherine Molloy Thomas Corcoran ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health Department of Health Important: If item 27 any Injury or other troonce. 1014 Somerset Dr, Glen Burnie, MD 21061 William J. McLaughlin Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bayview Crematory Oct 11, 2008 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Funeral Service Name and Address of Facility Fink Funeral Home, P.A. Fin Gregory MOT148 426 Crain Hwy S., Glen Burnie, MD 21061 Approximate Interval Between Onset and Death 23a. Part shock Enter the diseas or heart failure omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ply one cause on each line. Immediate Cause (Final **Physician** monic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) be executed Exami and burial-trar Due to (or as a consequence of): physician at the burial Box 68760, Physician/Medical law requires that the death certificate attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) P.0. ed by the detached 9 HInknown signed by 1 I be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ģ 1 Yes 2 No 3 Probably 4 Unknown icate has been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an The certificate 1 ☐ Yes 2 ☐ No 1 ☐Yes **Division of Vital** Hospital or Attending Physician: '24 hours after death. Funeral Director: After this certifica 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one Be 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient ၀ 1 ☐ Yes 2 ER/Outpatient 3 DOA 28c. Injury at Work? Certification: 27. Magner of eath Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital of within 24 hours a To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number s of person who completed cause of death (Item 23a) (Type, Print) 30. Name and Summe in Qate filed (Month, Day, 32. Registi State Registrar

			For State Registrar	State of M	aryland		artment r <i>tificate</i>			nd Me	ental Hy	giene Reg. No.	000	0	2201	1
			Decedent's Name (First, Middle, Las	st)						- 2	2. Date of De	eath	600	0	3. Time of Death	-
	Physici		Belva J.	Mod	refi	e1d				c	Month	23, Day	2008	ar	1:00 A	VI
	/Medic Examir		4a. Facility Name (If not institution, give				4b. City, 7	Town, or	Location of				County of D	eath		
			Dove House				We	esti	minst	cer			Car	rol	.1	
	Funeral		Social Security Number     6. Security Number	ex 7. Ag □ M <b>XIX</b> F	je (In yrs. la	ast birthday)	If Under		If Under 2 Hours	Min.	B. Date of Bir (Month, Da	rth ay, Year)	9.	Birthpla Countr	ce (State or Foreig	gn
22.	Director		230-20-4340	LIM ALAN	82	Yrs.		,-		N	lov.2	3,19			ginia	
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	the N 28a-i	Director	10e. Street and Number	<u> </u>								10a. Citi	izen of What	Countr		
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	ns 20	Funeral	11. Marital Status	12 Was Decedent	Ever in U.S		Was Deced			jin? (Spec	ify Yes or No ican, etc.)	D-	U . S 14. Race - A	mericar		
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21215-0036	filed within 72 hours after death with the Maryland Hygiene. wher than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notified at	Completed	15. Decedent's Ed (Specify only highest grad	lucation de completed)	Ţ	16a. Deced	dent's Usua	Occupa	ation furing most	of working	7	16b. Ki	ind of Busine	ss/Indu	stry	
2	thin re.	ng n	Elementary/Secondary (0-12)	College (1-4or	5+)		kind of wor			0	,		_			
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Pu	be fill ntal H <b>d oth</b> even	å	17. Father's Name (First, Middle, Last)								First, Middle		,			
7/3	2 should be and Mental is marked or raumatic eve	욘	Clarence C. J		n	401 14 11	Le1 i				M . N					
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Type. Print)  Linda DeMoss / Daughter  19b. Mailing Address (Street and Number or Rural Rout 3108 Old Westminster P:									er, City o Apt	r I own, Stat • Fin!	e, zıp c k s b	ode) ura, MD	)
e,	t and thealth sem 27 other tra		Linda DeMoss / Daughter 3108 Old Westminst  20a. Method of Disposition (Name of gemetery, crematory or other place)										Apt • Finksburg  20c. Location - City or Town, State			_
Baltimore,	Pages nent of I ant: If ite ury or of		XIX Burial 2 ☐ Cremation 3 ☐	Removal from State	l ce	metery, crer vergi	natory or ot	ther plac								
Ħ	it. Parturant ritant ritant njury		4 □ Donation 5 □ Other (Specify 21. Signature Fineral Service Licen		Mem	orial	l Gar	den					nksb		, MD pel P.A.	_
Ba	permit. Departm Importal any inju		21. Signature of America Service Licent	ennu-											s,MD211	
	Physician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	olications that cause one cause on each l a. Due to (or as	ne. YDR	4770	er the mode	e of dyin	g, such as o	cardiac or	respiratory a	arrest,			Approximate nterval Between Dnset and Death month	·
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68760,	ificate be executed g physician and as the burial-transit	al Examiner	that initiated events resulting in death) Last	Due to (or as	a consequ	ence of):										
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S, D	s that ned b deta		Part II. Other significant conditions of	ontributing to death b	ut not resul	ting in the ur	nderlying ca	use give	en in Part I.		23e. Did	tobacco ι	use contribut	e to the	cause of death?	
rds	quires n sign	d by	ASTIMA								1 🗆	Yes 2	No 3	] Proba	bly 4 □Unknow	'n
Record	w requir been si should	Completed									24a. Was	an	24b. Were	autops	sy findings available	le
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	ysicia is cert direct	o Be	examiner?	Hospital:	ent 2□E	R/Outpatien	t 3 🗆 DO	A Othe					6 Wother (9	Spacify)	HOSPICE	
ō	Attending Physician: r death. ector: After this certifica by the funeral director, I	n: To	27. Mann Death	28a. Date of Inju	ıry	28b. Time of		8c. Injun Work			3d. Describe			эреспу	11001100	
<u></u>	nding I ath. r; After e funer	ațio	1  Patural 5  Pending 2  Accident investigation	(Month, Da	y rear)	Injury	м		r Yes 2∐↑	40						
Division or	al or Attendated after death	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	ne, farm, str						(Street and Number or Rural Route Number, own, State)						
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical C		ysician: To the best niner: On the basis of and manner st	f examinati											
	To the within 7 To the Comple	Me	29b. Signature and title of certifier				29c.	. License	number			29d. Da	te signed (M	onth, D	ay, Year)	
<b>\</b>	- > - O		MASPIL		MANG		T	21	155	-		Octo	PAPR.	23	2008	

Registrar

State

DHMH 17 Rev 1/2001

**ORIGINAL** 

WESTMUSTER MARYLAND 21157

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

PETHULL PLOO, NO 904 WASHWOOD ROW

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 18 per fth 8884 10-24-08 Health and Mental Hygiene

			For State Registrar	State of tyle	•	epartment or r Certificate of			eg. No. 20 (	08 33941	
	Dhysisi		1. Decedent's Name (First, Middle, Last	1)		_		2. Date of Deat	h	3. Time of Death	
	Physici: /Medic		Robert		aurer			Oct.	19 200	08 11:11 PM	
	Examin	er	4a. Facility Name (If not institution, give				or Location of Death		4c. County of		
	Formul		1312 Breezeway D  5. Social Security Number 6. Se		e (In yrs. last birthe	(av) If Under 1 Year	polis   If Under 24 Hrs.	8. Date of Birth		Arundel Birthplace (State or Foreign Country)	
	Funeral Director			M 2□F	65 Yr	Months   Days	Hours Min.	8. Date of Birth (Month, Day, March 1	0 1943	Michigan	
	pu >		Usual Residence of Decedent  10a. State 10b. County		10c, City, Town o	r Location				10d. Inside City Limits	
	shov	or	10a. State 10b. County Maryland Anne Ar	undol	Toc. City, Town C		napolis			1 ☐ Yes 2 ☐ No	
	the M	Director	10e. Street and Number	under		10f. Zip Code	maports	1	0g. Citizen of Wha		
	3a or	al Di	1312 Breezeway D	rive			21409		ī	JSA	
	death	Funeral	11. Marital Status	12. Was Decedent 8 Armed Forces?	Ever in U.S.	13. Was Decedent of I		ecify Yes or No-	14. Race -	American Indian, White, etc.	
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene.  If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the "Midfall Eva". It is must be mailful at	ρ	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 Gyes 2 □ N If Yes, Give Year or Dates:	10	1 □Yes 2 No		Thousand overly	Specify:	White	
5-0	72 ho	Completed	15. Decedent's Edu (Specify only highest grad	ucation	16a. D	ecedent's Usual Occu	pation during most of work	ina	16b. Kind of Busin	ness/Industry	
121	/ithin ine. han "	mpl	Elementary/Secondary (0-12)	College (1-4or 5		Give kind of work done fe. DO NOT use retire lity Assur			US Gove	rnment	
	filed v Hygie ther t		12 17. Father's Name (First, Middle, Last)	2			18. Mother's Name				
Maryland	12 should be fil h and Mental H 7 is marked ot raumatic ever	To Be	Lynn Maurer				Irene	Stra	sbaugh _	Folmar	
ary	2 shoul and M is mar aumat	-	19a. Informant's Name/Relationship (7	ype. Print)	19b. N	failing Address (Street	t and Number or Rur	al Route Number	; City or Town, St	ate, Zip Code)	
	1 and 2 Health a tem 27 is		Leanna J. Maurer	(spouse	13	12 Breezew	ay Drive,				
Baltimore,	of He of He or oth		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐	Removal from State	20b. Place of D	isposition (Name of crematory or other pla	ce) Oct.	Date 23	20c. Location - Ci	ty or Town, State	
E	tment tant: jury o		4 □ Donation 5 □ Other (Specify	)	Metro (	rematory I				, Maryland	
Bal	permit, Pages 1 and Department of Health Important: If Item 27 any Injury or other tt Once.		21. Signatule of Euroral Service Licens	lee		22. Name and Address 3111 Mou	ess of Facility S Intain Roa	_		Home, P.A. 21122	
	23a. Part 1. Enter the lisease, or complications but caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause on each line.										
-	Physician	Immediate Cause (Final disease or condition resulting in death)  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of)									
Ŧ	/Medical Examiner										
		-	Sequentially list conditions,	b	e consequence of						
	uted d ansit	Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events	41414							
o,	an an		resulting in death) Last	Due to (or as	a consequence of)	•					
68760,	rificate be executed by physician and as the burlal-transit	edical		d							
	ertific ding p		IF FEMALE:	OGa If was suiteems	of prognancy				2000		
Box	leath cert attending I for use a	Physician/N	in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal death	3 ☐ Ectopic pregnan 5 ☐ Other (specify)	су		23d. Date		
P.O.	at the de by the tached	ysic	1 □ Ye s 2 □ No 9 □ Unknown	9 Unknown	tunie or death	5 E Other (specify)					
	res that signed b be deta		Part II. Other significant conditions co	· · · · · · · · · · · · · · · · · · ·	ut not resulting in t	ne underlying cause gi	ven in Part I.	23e. Did to	bacco use contrib	ute to the cause of death?	
Records,	w require s been sig should b	Completed by	Corona	"4 Hote	ery Di	sease		1 □ Ye	es 2 □ No 3	Probably 4 🗌 Unknown	
ဗင္ပ	law re as be 2 sho	plet		1				24a. Was a		ere autopsy findings available or to completion of cause of	
<u>=</u>	scertificate has birector, page 2 sl	Com						perfori	njed? dea	ath? ∐Yes 2∐No	
Vital	Iclan: certific ector,	Be	25. Was case referred to medical examiner?	Hospital:		Ot	26. Place of Deat				
of	ding Phys h. After this funeral dir	.T	1 ☐ Yes 2 No  27. Manner of Death	1 🗆 Inpatie	ent 2 ER/Outp	atient 3 1 DCA	4 LI Nursing Ho		ence 6 Other		
on	th. Afte	tion	1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Day	y, Year) Inji	ıry Wo	rk? ]Yes 2 □No	200. 200000	on injury occurred		
Division	Attend ar death ector: / by the f	ifica	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inju	ury - At home, farm c. <i>(Specify)</i>	, street, factory, office		28f. Location (Si City or Town	treet and Number	or Rural Route Number,	
Ö	tal or rs afte al Din ed in	Certification:	4 D Hornicide	building, etc	c. (opecity)			City or Town	n, state)		
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical			f examination and	death occurred at the to or investigation, in my					
	To the To the Comp	Me	29b. Signature and title of certifier	200	9	2.	se number			Month, Day, Year)	
			XIK	ell, IV	1)	Δ,	29193		Oclober	20,2008	
	10x1		30. Name and address of person who of Stephen Killian	completed cause of d		(pe, Print)	201. 2	dgewat	er, MD	20,2008	
		State Registrar  31. Date filed (Popular Day, Year) 32. Registrar's Signature									

DHMH 17 Rev 1/2001

ORIGINAL

# Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760, <

			Please	Type or Prin					•		•	
		For State		State of Ma	aryland		artment of rtificate o	f Health and of Death	Mental I	Hygier Reg. N	000	0 0001.0
		Registrar  1. Decedent's Name	e (First, Middle, Las	st)					2. Date o	f Death	- ( (J. l.)	3. Time of Death
Physicia /Medic		Mi	ichael P.	Machen					Octo	ber 1	7, 2008	7:32 P M
Examin				e street and number)	-		4b. City, Towr	n, or Location of De	ath	4	lc. County of Dea	
<b>.</b>	9	5. Social Security N		al Hospita		ast birthday)	If Under 1 Ye	01ney	rs. 8. Date o	f Birth	Montgon 9. Bi	nery rthplace (State or Foreign
Funeral Director		281-60-8	4	⊠ M 2□F	47	Yrs.	Months Da	ys Hours M	in. (Month	, Day, Yea	1960 Vir	ountry) 'ginia
		Usual Residence of	f Decedent 10b. County		100 City	Town or Lo	action					10d. Inside City Limits
faryla f shov	ō	Maryland		3 36 7 7	TOC. City	, lowing Lo		ckville				1 ☑ Yes 2 ☐ No
the A	Funeral Director	10e. Street and Nur	Montgome mber	=1 y			10f. Zip Cod			10g. (	Citizen of What C	ountry?
h with	al D	13913 B	Bauer Driv	ve .			2	0853		U	nited St	ates
ems (	ner	11. Marital Status		12. Was Decedent Armed Forces?	Ever in U.S	S. 13.	Was Decedent of	of Hispanic Origin? Suban, Mexican, Pu	(Specify Yes o	r No-	14. Race - Am Black, Whi	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Evander or unstitution diffed at once.	by	1 ☐ Never Marri 3 ☐ Widowed	ried 2 ☑ Married 4 ☐ Divorced	1 ∐Yes 2∏∏ If Yes, Give Year or Dates:	No		1⊡Yes 2½[1				Specify: W]	
72 hou natura	eted	(Spec	15. Decedent's Ed	lucation de completed)			dent's Usual Oc	cupation ne during most of v	vorkina	16b.	Kind of Business	/Industry
vithin ane. Ihan "	Completed	Elementary/Seco		College (1-4or 5	5+)	`life.	DO NOT use rei arpente	tired)	·g		Constru	uction
filed v Hygie other t	e Co	17. Father's Name	(First, Middle, Last)				arpence		lame (First, Mic	ddle, Maide		iccion
fental fental rked c	To Be	James	Turner N	lachen				Mar	y Marga	ret l	Duffield	
2 shou and M is mai			ame/Relationship (			19b. Maili	ng Address (Str	eet and Number or	Rural Route N	umber, City	y or Town, State,	Zip Code)
and dealth			na L. Mac	hen/Wife	0.01			Drive, R			aryland Location - City o	
ages 1 ant of h t: If ite y or ot			Cremation 3	Removal from State	Mon	ace of Dispo emetery, crei tgome:	osition (Name of matory or other ry um, Inc	oct	ober 26 108			Maryland
mit. Partme			5 ☐ Other (Specify uneral Service Licen		Grei	matori	Lum, Inc 2. Name and Ad	dress of Facility R		Pun	nphrey F	uneral Home
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate												
		shock, or hea	art failure. List only	plications that caused one cause on each li	d the death ne.	. Do not en	ter the mode of	dying, such as card	liac or respirato	ory arrest,		Approximate Interval Between Onset and Death
shock, or heart failure. List only one cause on each line.												
Examiner						ence of): iin In	inry					36 hours
,p ±	ner	Sequentially list con if any, leading to im- cause. Enter Unde Cause (Disease or	nditions, nmediate	Due to (or as			Jury				.,	30 Hours
eath certificate be executed attending physician and for use as the burial-transit	Examiner	that initiated events	S	c. Diabetes Mellitus							_	
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tificate g physas the	edic			d							1	
th cerr tendin r use a	an/M	IF FEMALE: 23b. Was deceden		23c. If yes, outcome 1 ☐ Live birth			⊒Ectopic pregn	ancv			23d. Date of de	
or Attending Physician: The law requires that the death certificate after death.  Director: After this certificate has been signed by the attending phys in by the funeral director, page 2 should be detached for use as the	Physician/Medica	in the past 12 1 ☐ Yes 2 [ 9 ☐ Unknown	□No	4 ☐ Pregnant a 9 ☐ Unknown	at time of de		☐Other (specify			-	Month	Day Year
w requires that the d s been signed by the should be detached				ontributing to death b	ut not resu	Iting in the u	inderlying cause	given in Part I.	23e.	Did tobacc	o use contribute	to the cause of death?
equires en sign	ed by								_   .	I∐Yes	2 □ No 3 □ F	Probably 4 Unknown
e law re has be je 2 sho	Completed									Nas an autopsy		autopsy findings available ocompletion of cause of
performed?   death?   1   Yes 2 ⊠ No   1   Yes 2 □ No												
siclan certifi rector	Be	25. Was case refer examiner?		Hospital:				Othor:	Death (Check o			
Position   1   Yes   2   No   No   No   No   No   No   No											ecify)	
ath. rr: Afte	atio	1 Natural 2 Accident	5 Pending investigation	(Month, Da	ıy, Year)	Injury		Vork? 1 □ Yes 2 □ No				
or Atte ter de irecto	ertification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined	28e. Place of Inj building, et			reet, factory, offi	се		on (Street r Town, St		Rural Route Number,
pital c	O	29a. Certifier	1□ Certifying Pl	nysician: To the best	of my know	wledge dea	th occurred at th	ne time date and pl	and due to	the earle	a(s) and manner	as stated
To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical	(Check only one)		niner: On the basis of and manner st	of examinat							
To th Withir To th	Me	29b. Signature and	Ittle of certifier					ense number	2 G	29d. I	Date signed (Mor	
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¢			ress of person who a Bandi, N	completed cause of d				rive, Olr	iev. Mai	vlan	d 20832	
Sta	te	31. Date filed (Mon	nth. Day. Year)	32. Registi	ar's Signat	ure	4		,,	,		
Registr			OCT 24	2008	MINES	All .	SEBALL !					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Charles incen edziwiecki 2008 tober /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner Baltimore City** The Johns Hopkins Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 2M 2 F 62 Feb. 24, 1940 Director Usual Residence of Decedent New 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f shov 27 Is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Haryland 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 21015 United. State 1112 Thebes -ive Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 Never Married 2 Married 1 XYes 2 ☐ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) 2 should be filed with and Mental Hygiene. CITY Bank san Ker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be vincent ပ္ Niedzwi Olga Nossan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) wife Department of Health a Important: If item 27 Is any injury or other trau Madeleine Niedzwieck Bel Hir 2 Thebes MD 21015 20b. Place of Disposition (Name of cemetery, crematory or other place)

22. Name and Add ss of Facility

Evens Fureau C 20c. Location - City or Town, State 20a. Method of Disposition Date 1 🗌 Burial 2 📈 Cremation 3 🗌 Removal from State 10/75/08 4 Donation 5 Other (Specify) Forest Hall 21. Signature of Funeral Service Licensee pel a Cremation Services-Bei Hir Forest Hall 3 Dempit Dr. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** nour disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last sician and burial-transit certificate be executed Due to (or as a consequence of): Box 68760, attending physician Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy The law requires that the death be detached for in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death 2 No P.0. the 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 🗌 Yes No 3 Probably 4 Unknown filled in by the funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \sum Nursing Home 2X No Hospital: 1 Inpatient 1 🗌 Yes 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) ည this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural After t 5 Pending investigation Injury or Attending 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A Accident Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide the Hospital X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number -29b. Signature any title of certifier ٥ ES-600 and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 10 233 ŽŮ08 Neroda Joanna /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Good Samaritan Nursing Home N/A Baltimore 9. Birthplace (State or Foreign Country) New Jersey 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 10/31/1909 7. Age (In vrs. last birthday **Funeral** Hours Months Davs Min. 1 □ M 2 🛛 F 216-01-8968 98 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examination at the modified at 1 X Yes 2 ☐ No Directo N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21239 U.S.A. 5662 Woodmont Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🕱 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No ò If Yes, Give Year or Dates: Specify 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mercantile Bank Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) æ Peter Neroda Eufymia Rajterowska ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 siment of Health an Arthur Lyons, Friend 5626 Loch Raven Blvd., Baltimore, MD 21239 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition ortant: If it injury or o permit. Page: Department of Important: If any injury or once. 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Svc. Corp. 10/27/2008 Towson, Maryland Leonard J. Ruck, Inc. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility lesandur y 5305 Harford Road, Baltimore, MD 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and the tor use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d, Date of delivery 3 🗆 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 M nknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒No 24a. Was an has autopsy performed? 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 1 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after deatle Funeral Director: filled in by the 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier ical (Check only and manner stated. within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

State

Registrar

Good Samaritan Hospital

Balto, MD. 21239

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

32 Registrar's Signature

Sireesh K. Tripuraneni

31. Date filed (Month, Day, Year)

OCT 24

08-07928 Craig Noppinger Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

alg Nopplinger		1- For State Certificate O	f Death	Reg. f	No.	394
Physician	_	Registrar  1. Decedent's Name (First, Middle,Last)		Date of Death     Month Da	3, Time of Dea	
edical Examin	er	Craig T. Noppinger		October 21, 2	2008 1315 hrs	
	4	Facility Name (if not institution, give street and number)     9208 Avondale Road	4b. City, Town, or Location of Deat Parkville		Baltimore County	
Funeral Director	. 5	5. Social Security Number 213-72-2897 6. Sex 17. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hi Months Days Hours Mi	_	MM/DD/YYYY) 9. Birthplace (State of Foreign Country)MD	
		Usual Residence of Decedent  10a State 10b County 10c. City, Town or Loca	tion		10d. Inside Cit	y Limits
and show any nce.		Tod. State	timore		1 Yes 2	X No
anylam 8a-f sh	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?	
the M		9208 Avondale Road	21234		SA	. ot
h with		1 Never Married 2 Married Armed Forces?	as Decedent of Hispanic Origin? ( Yes, specify Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - American Indian, Blace White, etc.	CK,
0		Widowed 4 Divorced If Yes, Give Year 1	Yes 2 X No specify:		Specify: White	
ours af	함	Lor Dates:	ent's Usual Occupation (Give kind o most of working life. DO NOT use n	f work done 1 etired)	6b. Kind of Business/Industry	
66 n 72 hc nan "na ical Ex	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	ancial Consult		Financial	
21215-0036 Juld be filed within 72 Mental Hygiene. marked other than ic event, the Medical	E -	17. Father's Name (First, Middle, Last)	18.Mother's Na	ne (First, Middle, Ma	iden Surname)	
215. oe filed ntal Hy ked of	8	Nicholas Noppinger	Marga	aret Tay	lor	
21 hould the is mar	P	19a Informant's Name/Relationship (Type, Print)  Nicholas Noppinger /father	ng Address (Street and Number of 601 Virginia			
ore, MD 21215-003 ss 1 and 2 should be filed withi of Health and Mental Hygiene. If iten 27 is marked other the	-	20a Method of Disposition 20b. Place of Dispo	osition (Name of cemetery,		20c. Location - City or Town, State	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical		1 Burial 2 X Cremation 3 Removal from State Bayviev	w Crematory	10/27/08	Baltimore MD	,
Iltim nit. Pa artmer sortani	+	4 Daysign 5 Other Specify  21. Six aut of Fune 1 Service Liceopt 22.	Name and Address of Facility	300 Mac	e Ave. Balto.	MD
B P P I		23a Part I. Enter the disease, or complications that caused the death. Do not enter	Connelly Fund	eral Home	e of Essex 212	21 e Interval
Physician		failure. List only one cause on each line.		o or respiratory arras	Between O Dea	inset and
aminer	- 1	Immediate Cause (Final disease or condition resulting in death)  a. Gastrointestinal  Due to (or as a consequence of):	nemorrnage			
	ner	Sequentially list conditions, if any, leading to immediate causs. Enter Underlying Cause				
ed	Examine	(Disease or injury that initiated events resulting in death) Last  C.  Due to (or as a consequence of):				
760, cate be executed physician and the burial - transit	Medical		rME, g884 10/30/	08 TT		
760, icate be physic the bur			Fetal death 3 Ectopic pre	gnancy	23d. Date of delivery  Month Day	Үеаг
Box 687 e death certific the attending p	Physician/	past 12 months?  1 Live birth 2 4 Pregnant at time of death 5	Other (Specify)	,		
Bo) The deatl The att	hys	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tob	pacco use contribute to the cause of	death?
, P.O. ires that the signed by be detach				1 Yes	2 No 3 Probably 4 🗸 L	Jnknown
ords, w require as been signshould b	Completed by			24a. Was a autops		available cause of
COF re law te te has te ge 2 sh	ldmo			perform 1 ✓ Yes 2		No
of Vital Recing Physician: The After this certificate Uneral director, page	Be C	25. Was case referred to medical	26.Place of Death (Ch			
Vita hysici r this c	To B	1 ✓ Yes 2 No			Residence 6  Other: Scene ow injury occurred	
n of ding F h : After : funer			1 Yes 2 No		, ,	
Division of Vital Records, P.O. fat or Attending Physician: The law requires that the safer death.  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detact	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, s	treet, factory, office building, etc.	28f. Location (S or Town, St	treet and Number or Rural Route Nu ate)	mber, City
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transitions.	al Cer	4 Homicide determined (Specify)  29a. Certifier 1 Certifying Physician: To the best of my knowledge, death or (Check only)	courred at the time, date and place,	and due to the cause	e(s) and manner as stated.	
To the within To the comple	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or invest and manner stated.	29c. License number	on the time, date t	29d. Date signed (Month, Day, Yea	ır)
	Σ	29b. Signature and title of certifier	O.C.M.E.		October 22, 2008	
(1)		30. Name and address of per on who complet in cause of death (Item 23a)				
		Jack Titus MD. Deputy Chief Medical Examiner 111 F	Penn Street, Baltimore, MD	21201		
	tate		· trysille.			
Regis		America	NAL		OCWI	
LICHMEN LA REVIII	LUUI	ORIGI	· · · · <del>- ·</del>			

Jemes Villiam Cliver Jr.   Security Number   Sex   Sex   7 Age (in yes. lest birthday)   Baltimore   Sex   Towns of Location of Death   Sex   Towns of Location	MD Inside City Limits Yes 2 X No Indian, Black, American Y
4a. Facility Name (if not institution, give street and number)  4b. Colly, Town, or Location of Death Baltimore  5000 block of Perring Parkway  5. Social Security Number  6. Sex  218-15-6884  1	MD Inside City Limits Yes 2 X No Indian, Black, American Y
5. Social Security Number  10.	MD Inside City Limits Yes 2 X No Indian, Black, American Y
218-15-6884  218-1	MD Inside City Limits Yes 2 X No Indian, Black, American Y
To a state   10b. County   10c. City, Town or Location   10d.   1	Yes 2 X No Idian, Black, American  Y  Code)
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Objects or injury that initiated events resulting in death) Last  Objects or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  OU. C. Specification of the properties of th	
OS CONTROL OF CONTROL	
Sport of the past 12 months?  1	
So you have a serious and seri	100
OC Complete the part of the pa	Year
So Did tobacco use contributing to death but not resulting in the underlying cause given in Part I.  Yes 2 No 3 Probably  24a. Was an autopsy performed?  24b. Were autopsy performed?	
24a. Was an autopsy prior to comple autopsy performed?	
O E   performed?   death?	
## 일 등 등 등   1 ▼ Yes 2 No 1 ▼	2 No
O D S S S S S S S S S S S S S S S S S S	
Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other: Scen	ie .
Construction of the state of th	
Oct 18, 2008 or 19 oct	
D string by the string Parkway, Baltimon determined (Specify) Major Road (6500 block of Perring Parkway, Baltimon determined (Specify) Major Road (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	e, MD
3 Suicide 6 Could not be determined (Specify) Major Road  3 Suicide 6 Could not be determined (Specify) Major Road  3 Suicide 6 Could not be determined (Specify) Major Road  4 Homicide 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Determined)	
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Date signed (Month, Date signed (Month, Date signed (Month, Date signed (Month), Date signed (	
30. Name and address of person who completed cause of death (Item 23a)	se(s)
Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	se(s)
State 31. Date filed (Month, Day, Year) Registrar  32. Registrar's Signature	se(s)

			1 - For State Registrar	State of Maryl	and / Depa	artment of F	lealth and Me		7000	33947
	Obveio		Decedent's Name (First, Middle, La	ist)		initiatio or i		Reg. 2. Date of Death		3. Time of Death
·	Physici /Medi		MARIYS	Hear	ce			M9nth :	23 OE	3 10 Am
-	Examir	er	4a. Facility Name (If not institution, given the control of the co	re strater and number)	\)	4b. City, Town, or	Location of Death		4c. County of Dea Baltimo	
	Funeral		5. Social Security Number 6. S		vrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	9. Bi	thplace (State or Foreign
	Director		568-24-3618 Usual Residence of Decedent	1□ M 2√2.F	81 Yrs.	Months Days	Hours Min.	(Month, Day, Ye 10/03/19		o <i>untry)</i> nesota
	yland Now		10a. State 10b. County	10c.	City, Town or Lo	cation				10d. Inside City Limits
	Ba-fet	Director	Maryland Balti	more	Timoniu	a				1 ☐ Yes 2∕ No
	sa or 2	I Dire	10e. Street and Number 2405 Eastridge	Road		10f. Zip Code 210	93	U	Citizen of What C nited St	atés
	ame 2	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?		Was Decedent of H	ispanic Origin? (Specin, Mexican, Puerto R	ifv Yes or No-	f Americ	erican Indian.
21215-0036	permit. Pagas 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itame 23a or 28a-f ehow any injury or othar traumatic event, I've Medical Examinst must be notified at once.	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☒No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No	Specify:	ilicani, etc.)	Black, Whi	
2-0	"natur	Completed by	15. Decedent's E (Specify only highest gro	ducation ade completed)	16a. Deced	dent's Usual Occupa	ation during most of working	16b	. Kind of Business	Vindustry
12	withir iene. then	dwo	Elementary/Secondary (0-12)	College (1-4or 5+)		oo not use retired nemaker	0		Residen	
	al Hyg	BeC	17. Father's Name (First, Middle, Last		11011	TOTAL CE	18. Mother's Name	(First, Middle, Maid		ce
Maryland	Ment Ment	2	Leonard Mid					unanda Ne		
Z Z	th and 2 st lith and 27 is m		19a. Informant's Name/Relationship ( Pamela Pearce Kin				and Number or Rural ton Circle			
ore,	of Healifem		20a. Method of Disposition	201	b. Place of Dispo		Da	te 20c	Location - City or	
altimore,	Pagas ment of i ant: If its ury or o		1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	Removal from State	Evans Fu	meral Cha	e) Octob apel 24, 2	008 Fo	rest Hil	l, Maryland
Ball	permit. Depart Import any inj		21. Signature of Theral Service Lice	1598	P32	Name and Address 2325 Yo	Tternative ork Road	s Funera Timonium	l &Crema	tion Ctr.,P.1
Ì			23a. Part1. Enter the disease, or comshock, or heart failure. List only	plications that caused the done cause on each line.	eath. Do not ente	er the mode of dying	g, such as cardiac or	respiratory arrest,	,	Approximate Interval Between
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ì	Examiner			Due to (or as a cons	sequence of):					
4	TD ==	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a cons	requence of):					
٧	icate ba exacuted physician and s the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a cons	cognopes of					
68760,	e ba ex sician e buria			200 to (or as a cons	sequence or).					
_		Aedical	le seum e	u.						
O. Box	at the death certific, by the attending pl tached for use as t	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of preduction 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of 9 ☐ Unknown	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
νς σ	law raquires that the as been signed by th 2 should be detache	by Ph	Part II. Other significant conditions of	ontributing to death but not	resulting in the un	iderlying cause give	en in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
Sign	w raquire been sig should b							1 ☐ Yes	2 □ No 3 □ P	obably 4 Junknown
Hecords,	0 5 0	ompleted						24a. Was an autopsy performed	prior to death?	utopsy findings available completion of cause of
VII	in:	BeC	25. Was case referred to medical examiner?				26. Place of Death (		10 100	2 140
0	Phys this	2	1 Yes 2 100	Hospital: 1 ☐ Inpatient 2  28a. Date of Injury	☐ ER/Outpatient	3 DOA Othe	4 Nursing Home	5 ☐ Residence d. Describe how in		cify)
0	nding i ath. r: After a funer	atlon	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year,	Injury	Work	es 2 □No	d. Describe now in	jury occurred	
UNISION	To the Hoepital or Attanding within 24 hours after death. To tha Funaral Diractor: After completely filled in by tha funer	Certification;	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, stre	et, factory, office	28	f. Location (Street City or Town, Sta		ural Route Number,
	To the Hoepital or within 24 hours afte to tha Funaral Discompletely filled in		29a. Certifier 1 Certifying Ph	ysicien: To the best of my k	nowledge, death	occurred at the tim	e, date and place, an	d due to the cause	(s) and manner as	stated.
	the H hin 24 tha F nplete	dedical	one) Z Medicer Exer	niner: On the basis of exam and manner stated.	ination and/or inv	estigation, in my op	inion, death occurred	at the time, date a	and place, and due	to the cause(s)
ı	Viii To	Σ	29b. Signature and title of certifier			29c. License	number	29d. [	Date signed (Mont	h, Day, Year)
	18		30. Name and address of person who	completed cause of death (II	tem 23a) (Type F	Print)	ادדاب		10/24/	2008
	10		R GAN-CARDE	N,6565	N.CH		ST, PPE	209,B	alto, M	D21204
	Stat Registra		31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature	Page 18 a	/		7	
	3.541		00124	LUUV Juliani	o for the	The state of				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend items 6.9 per fh 9884 10-24-08 yt
State of Maryland / Department of Health and Mental Hygiene

			for State Registrar	State of t	wai yiaria		rtificat			rid ivie	Re	g. No.	nna	0 0001
	Physici	an	1. Decedent's Name (First, Middle							2	. Date of Death Month	Day	Year	3. Time of Death
	/Medic				d Lee P	oe.					CTOBER	22	2003	10:05 A.M.
	Examir	er	4a. Facility Name (If not institutio		er)		4b. City,		Location of	Death		4c. County		211
	F		5. Social Security Number		Age (In yrs. las	st birthdav)	If Under		If Under 2	4 Hrs.   8	. Date of Birth			nore City ace (State or Foreign
	Funeral Director		215-40-3294	1 <b>⊠</b> M 2□ F	65	Yrs.	Months	Days	Hours	Min.	(Month, Day,	Year) 5, 1943	Coun	ace (State or Foreign
	pt ,		Usual Residence of Decedent		T						- Juli I	J, 1345		
	arylar show	<u>_</u>	10a. State 10b. County	Baltimore	10c. City,	Town or Lo	cation		0	- 0-1			10	d. Inside City Limits 1 □Yes 2 No
	the M	ectc	10e. Street and Number	Baitimore			10f. Zip	Codo	Gwyn	n Oak	10	g. Citizen of	Mhat Count	/\
	with with the r	ä	6018 Harford Ave.				101. 210	Code	212	07	10	g. Onizen or	U.S	•
	death ms 2;	<b>Funeral Director</b>	11. Marital Status	12. Was Decede	ent Ever in U.S.	13. \	Was Deced	lent of Hi			fy Yes or No- can, etc.)		ce - America	an Indian,
9	72 hours after death with the Maryland natural", or items 23a or 28a-f show fileol Exa. ulver must be notfilled at	E/	1 ☐ Never Married 2 Mar	ried Armed Force 1 ☐ Yes 2 If Yes, Give	No No	i i		No	n, Mexican,  Specify:	Puerto Hi	can, etc.)		ck, White, e	
5-0036	ural",	d by	3 Widowed 4 Divorced	Year or Date	es:			7				Specify	VVI	
15	n 72 ł n "nati	Completed	(Specify only highe	it's Education st grade completed)		16a. Deced (Give life. L	dent's Usua kind of wor DO NOT us	al Occupa rk done o se retired	ation <i>Juring most (</i> )	of working	1	6b. Kind of B	usiness/Ind	ustry
2121	filed within Hygiene. ther than "	E O	Elementary/Secondary (0-12)	College (1-4	or 5+)				ft Opera			Machi	narv Ma	anufacturing
	al Hyg other	Be C	17. Father's Name (First, Middle,	Last)							First, Middle, M			and the state of t
/lar	should be fi and Mental h s marked ot umatic ever	TO E		John Ver	non Poe						Mary A	Alverta M	erryma	n
Maryland	2 sho and is ma		19a. Informant's Name/Relations	ship (Type. Print)		19b. Mailin	ng Address	(Street a	and Number	or Rural I	Route Number,	City or Town,	State, Zip	Code)
2	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any lolury or other traumatic event, it is Medical Exa. Juver must be notified at any lolure.		Mary Poe Wife		201 01-						c, MD 2120		0" - T-	
Baltimore,	nt of h		20a. Method of Disposition  1 □ Burial 2 □ Cremation		ate 200. Placen	ce of Dispo netery, cren	natory or o	ther place	e) :	Dat		0c. Location -	- City or To	vn, State
Ħ	permit. Page Department Important: If any Injury o		4 Donation 5 Dother (\$ 21. Signature of Funeral Sirving		The state of the s	Good Sh			tery :	Oct 2	27, 2008	Ellic	cott City	y, Maryland
Ba	permit. Departr Importa any Inji		21. Signature of Pulleral Style	Mister	JI True	1295 22	s	lack F	uneral H	ome, P.	A <u>.</u>			
			23a. Part 1. Enter the disease, or shock, or hear failure. List	complications that cau	sed he death.	Do not ente	er the mod	e of dyin	g, such as c	bia Pike ardiac or i	Ellicott Ci espiratory arre	<b>ty, MD 21</b> st,	043	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	only one cause on each	n line.	1	0000		MEGA	OT	land		4	Onset and Death
	/Medical		resulting in death)	a. Due to (or	as a conseque	nc of):	16/11	-	miri	3,-1	1014		- 1	MEINE LUNG
	Examiner	L	Sequentially list conditions.	b. Vent	RICUI	AR	TAG	HY	CARD	19			ei	ant hours
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or	as a conseque	nce of):	20100	121	CD 21	$\sim$				
	and al-tran	xan	that initiated events resulting in death) Last	c. TCUT	as a conseque	nce of):	MAN	4	FUE	111			10	ed hours
68760,	e be e siciar	Sal		L. COR	MARY	1 AR	TPR	j	1)158	LASE			+	EN VEARS
.89	rtificate be executed ng physician and as the burial-transit	Medical		u.					<b>V</b>					33 451113
Вох	eath cer attendin for use	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	me of pregnand th 2 ☐ Fetal d		] Ectopic p	regnancy	,				te of delive	
O. B	e dea he att	Physician/I	in the past 12 months? 1 □ Yes 2 □ No	4 ☐ Pregnar	nt at time of dea		Other (sp					Mo	onth	Day Year
P.	res that the de signed by the a be detached f	Phy	9 Unknown			ng in the ur	adorlying o	auga eluc	n in Bort I		22e Did tob	2000 USO 0001	tributa to th	e cause of death?
ds,	signe signe	l by	Part II. Other significant conditi		AND C		Was 1	ause give	mmrani.					ably 4 Unknown
Ö	v requi	Completed	O OCTATE O	10171711	<del>†1112</del>	71/2	1100	<u> </u>		- 11				
Re	he law e has ge 2 s	ld la	PIHORIES I	KLL I W	,						24a. Was an autopsy perform		prior to con death?	sy findings available apletion of cause of
tal	sician: The la certificate ha irector, page 2		25. Was case referred to medica						26 Place	of Dooth (	1 □Yes 2, Check only one		1 🗀 Yes	2 □ No
of Vital Records,	Physicia this cer al direct	To Be	examiner? 1 ☐ Yes 2 🗷 No	Hospital:	atient 2 EF	R/Outpatien	ıt 3□DC	Othe	r.		5 Resider		ner (Specify	-)
0 4	ding Phy h. After thi funeral c	L:uc	27. Manner of Death 1 ☑ Natural 5 ☐ Pendir	28a. Date of (Month,	Injury 2. Day, Year)	8b. Time of Injury	2	8c. Injury Work			d. Describe hov			<i>(</i>
Division	tendi eath. tor: A	Certification:	2 Accident investi	gation			М	1 🗆 1	res 2□N	0				
ĬĬ	I or Attendi after death. Director: A I in by the fu	rtifi	4 Homicide determ	inod Zoe. Place of	Injury - At hom, etc. (Specify)	e, farm, stre	eet, factory	, office		281	Location (Street). City or Town,	eet and Numb State)	per or Rural	Route Number,
ч	To the Hospital or Attending Physician: The law requires that the death ce within 24 hours after death. Within 24 hours after death. To the tuneral Directors After this certificate has been signed by the attendit completely filled in by the funeral director, page 2 should be detached for use		29a. Certifier 1 <b>X Certifyl</b> i	ng Physiclan: To the be	est of my knowle	edge, death	n occurred	at the tin	ne. date and	nlace an	d due to the ca	use(s) and m	anner as si	ated
	e Hos 24 h e Fun letely	Medical	(Check only 2 Medical one)	Examiner: On the basi and manner	is of examinatio	n and/or in	vestigation	, in my o	oinion, death	occurred	at the time, da	te and place,	and due to	the cause(s)
	To the within To the Comp	Me	29b. Signature and title of certifie	1000 000 000	1. 0	1		. License	number		29	d. Date signe	d (Month, L	Day, Year)
			Advang Dok	WITH H	tending f	nysici	AN MY	AR-YLA	NO DO	10417	11 0	stober	. 22	,2008
	0,		30. Name and address of person	who completed cause of		3a) (Type, I	Print)	Λ	110	.1-				
	1		JONATHAN S	AFREN MD	3449	·	LENS	HISH	We, Si	HP 3	Bac BA	LTIMOPE	一川的	4AND 21229
	Sta Registr		31. Date filed (Month, Day, Year)		istrar's Signatur	2.	0 -	***						
DHI	MH 17 Rev 1/2		<u>UU1 2</u>	4 2008	SHAN A	7 19	204/2	8						
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KONALD 1. 50E

			State of Maryland / Department of Health and Me  1 - Registrar  Certificate of Death		ene .No.2008	33949
	_			2. Date of Death		3. Time of Death
	Physicia /Medic		Peter C. Pastore	Month October	20 2006	16181
	Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death		4c. County of Deat	
ari .			University of maryland medical Center Baltimore	۷	N/A	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8  O 2 0 4 2 3 5 0 4 1 M 2 F 5 9 Yrs.   Months Days Hours Min	B. Date of Birth (Month, Day, Y	ear) Co	nplace (State or Foreign untry)
	Director		020-42-3594   15 m 20   58   Yrs.   Usual Residence of Decedent	July 9,1	950 Que	ens New York
	/land		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	a-f sh	ctor	Maryland Anne Arundel Glen Burnie			1 ☐ Yes 2 🔀 No
	or 28	Oire	10e. Street and Number 10f. Zip Code	10g	. Citizen of What Co	untry?
	death with the Maryland ims 23a or 28a-f show round be nottlind at	Funeral Director	7209 Oakwood Road 21061		USA	
	er dez	nue	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Speci If Yes, specify Cuban, Mexican, Puerto Ric	ify Yes or No- ican, etc.)	14. Race - Ame Black, White	
0000	rs afte	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give 1 ☐ Yes 2 ☒ No Specify: Year or Dates:		Specify: Wh	ite
2	2 hou		15. Decedent's Education 16a. Decedent's Usual Occupation	16	b. Kind of Business/l	ndustry
2 2	hin 72 9. 8. "n" M. M.	ple	(Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)  Elementary/Secondary (0-12) College (1-4or 5+)	'		
7	d with	Completed	12 +4 Truck Driver		UPS	
yland	be file tal Hy d oth event	Be	17. Father's Name (First, Middle, Last)  18. Mother's Name (I	First, Middle, Ma		
<u>X</u>	S should be filed within 72 hours after death with the Marylan and Mental Hygiens is and Mental Hygiens is marked other than "natural", or items 23a or 28a-f show aumatic event, it a Modical Examinar mast be matthed at	To			Mull	
M	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic evonce.	ľ Ì	19a. Informant's Name/Relationship (Type. Print)19b. Mailing Address (Street and Number or Rural IsVincent C. Pastore7209 Oakwood Road Glen			îp Code)
ē,	is 1 and 2 soft Health a item 27 Is other trau		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)	te 20	c. Location - City or	own, State
Ē	Page nent c nt: If nry or		1₺ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)  MD Veterans Cemtery 10/24/	/2008 C	rownsvill	e Maryland
Baltimor	permit. Departn Importa any Inju		21. Signal are of Funeral Service Licensee 22. Name and Address of Facility	llings F	uneral Ho	me P.A.
מ	89 = 89		3111 Mountain Road	Pasaden	a MD 2112	
			23a. Part 1. Enter the disease, or complications bet caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only ore cause on each line.	respiratory arrest	ι,	Approximate Interval Between
F	Physician	n i	Immediate Cause (Final disease or condition			Onset and Death
1	/Medical Examiner		resulting in death)  Due to (or as a conseque ce of):			
•	ZXUIIIIICI	<u></u>	Sequentially list conditions, b. Myo Cordiol Inforction			3 weeks
/	nsit nsit	nin	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.			
	execunand al-tra	Examiner	that initiated events c Due to (or as a consequence of):			
2	cate be executed physician and the burial-transit	dical	d			
0	rtifica ng phr as th				I	
202	th cer tendir r use	an/N	IF FEMALE: 23b. Was decedent pregnant in the part 12 months? 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy		23d. Date of del	,
	Attending Physician: The law requires that the death certific death.  sector: After this certificate has been signed by the attending pector. After this certificate has been signed by the funeral director, page 2 should be detached for use as	Physician/Me	in the past 12 months?  1		Month	Day Year
Ţ.	hat th			23e. Did tobar	co use contribute to	the cause of death?
ecords,	ires ti signe	by			2 □ No 3 □ Pr	
	v requ	etec		24a. Was an		
Ĕ	he lav	Completed		autopsy performe	d?   death?	topsy findings available completion of cause of
	in: Th		an Miles of the state of the st	1 □Yes 2	No 1 □ Yes	2 □No
>	ysicia s cert	o Be	examiner?		ce 6 ☐ Other (Spec	rifu)
VISION OF	g Phy ter thi	n:T	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28	3d. Describe how		any)
2	endin ath. or: Aff	atio	2 Accident investigation M 1 Yes 2 No			
<u>2</u>	r Atterdeter de irecto	Certification: To	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28	If. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,
ב	oital o urs aft eral Di					
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending p. completely filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier 1 ✓ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, an (Check only one) 1 ✓ Medical ExamIner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.			
	o the		29b. Signature and title of certifier 29c. License number	290	. Date signed (Monti	n, Day, Year)
	->-0		> Lifformy Bridges P19665		Act 20	,2008
	CXI		20 Name and address of payon who completed gaves of death (flow 22s) (Type Print)			
	2		Tiffany Bridges 22 S. Greene St. Bultimore, MD 212	101		
	Sta		31. Date filed (Month, Day, Year)  32. Registrar's Signature  32. Registrar's Signature			
	Registr	ar	UC   2 4 6000			

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	state of Ma		ertificate of		Mental Hyg	iene eg. No.2 A A R	22050
	Dharin		1. Decedent's Name (First, Middle, Last)					2. Date of Deat	h	3. Time of Death
	Physici /Medi		Betty Lee Phillips					October	21, 2008	12:28P M
	Examir	ner	4a. Facility Name (If not institution, give stre	et and number)		4b. City, Town,	or Location of Dea		4c. County of Dea	th
		ш	Suburban Hospital			Bethes			Montgomer	ry
	Funeral Director		5. Social Security Number 6. Sex 1 □ N	7. Age	(In yrs. last birthda 80 Yrs	y) If Under 1 Year Months Days		(Month, Day,	9. Bir (Co. 928 Was	thplace (State or Foreign buntry) Shington, DC
	pu		Usual Residence of Decedent  10a. State 10b. County		10- 0't T-					
	laryla sho	5			10c. City, Town or					10d. Inside City Limits
	the N	ect	Maryland Montgomery	7	Rockvill			1.7		1 X Yes 2 □ No
	with Sa or	<b>Funeral Director</b>	721 Mapleton Road			10f. Zip Code			og. Citizen of What Co	,
	ms 2;	Jera		Was Decedent Ev	ver in U.S.	20850 Was Decedent of	Hispanic Origin? (5		nited Stat	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, its Modical Examines must be notified at once.	oy Fur	1 □ Never Married 2 □ Married 3 🕅 Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 📉 No If Yes, Give		If Yes, specify Cu 1 ☐ Yes 2 🛣 No	Hispanic Origin? (S ban, Mexican, Puer Specify:	to Rican, etc.)	Black, White	e, etc.
ŏ	2 hou	Completed by	15. Decedent's Educati	Year or Dates:	16a, De	edent's Usual Occu	ination		wn	ite
215	nin 72 e. an "ne	plet	(Specify only highest grade of Elementary/Secondary (0-12)	ompleted)	(Gi	re kind of work done DO NOT use retire	ed) during most of wo	rking	6b. Kind of Business/	industry
21	d with giene er tha	No.	12	College (1-4or 5+)	)	nistrativ		1	Telephone	Company
nd	e file al Hy d oth	Be (	17. Father's Name (First, Middle, Last)				18. Mother's Nar	ne (First, Middle, M		- opatty
yla	Ment Ment arkec	7	Benjamin Oldfield					Westfall		
lar	2 sho		19a. Informant's Name/Relationship (Type.	Print)	19b. Ma	ling Address (Stree	t and Number or R	ural Route Number,	City or Town, State, 2	Zip Code) 02657
e é	l and lealth im 27 her t		Mark Lee Phillips/So	on	12 W	inthrop S	Street, P	rovinceto	wn, Massac	husetts
Baltimore, Maryland 21215-0036	iges in the state of the state		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Rem	val from State	20b. Place of Dis	position (Name of ematory or other pla Memoria	ce) Octo	ber 25,	0c. Location - City or	•
Ħ	it. Pa		4 ☐ Donation 5 ☐ Other (Specify)	1	ı Pa	rĸ	;2000	R	ockville,	Maryland
Ba	Depa Impo any I		21. Signature of Funeral Service Licensee	<u>0</u> 1	M00896	22. Name and Addr ethesda-( ethesda.	ess of Facility NO Thevy Cha: Maryland	se, Inc. 20814-3	umphrey Fu 7557 Wisco 501	neral Home/ nsin Avenue
Е			23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one complications are complicated as the complex of the co	ons that caused th						Approximate Interval Between
-	Physician		Immediate Cause (Final disease or condition			lure with				Onset and Death
j	/Medical Examiner		resulting in death)		consequence of):		. Myponia			
		<u>.</u>	Sequentially list conditions, b. —			d Nephrop	athy			
7	ted 1sit	Examiner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c		consequence of).					
/	execu and al-trai	xar	that initiated events c c	Heart F	consequence of):					
68760,	death certificate be executed e attending physician and d for use as the burial-transit	Medical I	d	Bactere	,					
φ ×	ertific ding p	Med	IF FEMALE:							
O. Box	e death cer the attendir red for use	Physician/I	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No	If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at til 9 ☐ Unknown	Fetal death 3	☐ Ectopic pregnand ☐ Other (specify) _	су		23d. Date of deli Month	very Day Year
J.	hat thed by letach	Ę.	g ☐ Unknown	Non-to-de-state to-de-				T		
Vital Records,		ed by	Part II. Other significant conditions contrib	ung to deam but r	not resulting in the	underlying cause gi	ven in Part I.	- 1	cco use contribute to 2 ☐ No 3 ☐ Pro	the cause of death?  bbably 4 🖔 Unknown
•	law re as be 2 sho	plet						24a. Was an	24b. Were aut	opsy findings available
<u> </u>	The yate h	Completed						autopsy performe 1 ☐ Yes 2)	eq?   death?	ompletion of cause of 2 □ No
<u> </u>	clan: ertific ector,	Be	25. Was case referred to medical examiner?				26. Place of Dea	th (Check only one)	LINO   1 Hes	2 🗆 100
6	hysi this o	၉	1 ☐ Yes 2 📉 No	1/L_Inpatient	2 ER/Outpatie	nt 3 □ DOA Oth	ner: 4  Nursing H	ome 5 Residen	ce 6 ☐Other (Spec	ify)
ב ב	ling F	ü	27. Manner of Death 2  1 X Natural 5 ☐ Pending	8a. Date of Injury (Month, Day, Y	(ear) 28b. Time Injury	of 28c. Inju Wor	ry at	28d. Describe how		
Sion	ttend death death tor:	cat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be				lYes 2□No			
2	tal or A rs after al Direc ed in by	Certification:	4 Homicide determined 2	8e. Place of Injury building, etc. (	- At home, farm, s (Specify)	reet, factory, office		28f. Location (Stre City or Town,	et and Number or Rui State)	ral Route Number,
:		Medical	29a. Certifier 1	in: To the best of r On the basis of ex and manner stated	kamination ang/or i	th occurred at the ti	ime, date and place opinion, death occu	, and due to the cau rred at the time, dat	use(s) and manner as e and place, and due	stated. to the cause(s)
i	Vith Com	Σ	29b. Signature and title of certifier	. >		29c. Licens	se number	290	I. Date signed (Month	, Day, Year)
	10		Uma//purl	- ten	16-	DOOL	65/82	1	0121108	
	0		30. Name and address of person who comple						1 311 30	
	1		Sima Nourani Zenuz, 31. Date filed (Month, Day, Year)		600 Old (	Georgetow	n Road, B	ethesda,	Maryland	20814
	State Registra		OCT 2.4 2008	32. Registrar's		Cast 1				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day VICTOR RUBINSON P M /Medical 4:00 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Trunder 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 04/14/19/20 N/A Sing Hospital of Baltimore

5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** 6. Sex 1 M M 2 □ F 9. Birthplace (State or Foreign Yrs. 106-18-6891 Director 88 NY Usual Residence of Decedent the Maryland 10a. State 10h. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits **Funeral Director** BALTIMORE OWINGS MILLS 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with i Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any Injury or other traumatic event, the Medical Examilian must be I 4730 ATRIUM COURT, #511 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ∭2Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 □Yes 2 No WHITE \$ 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SUPERVISOR SOCIAL WORK 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HYMAN RUBINSON IDA SEIDMAN ٥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HARRIET RUBINSON / DAUGHTER 50 BARBICAN WAY, BALTIMORE, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State NEW MONTEFIORE CEM. 10/23/2008 PINELAWN, NY 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Metastaho Multiple Myeloma /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Liner underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) that the death certificate be executed and physician a the burial-t Due to (or as a consequence of): Box 68760, Physician/Medical attending p for use as t IF FEMALE 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 4 Pregnant at time of death P.O.1 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 23e. Did tobacco use contribute to the cause of death? 2 Atrial Ribrillation has been s e 2 should | Completed 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? page autopsy perform rmed? 2 No 1 ☐Yes 2 ☑No 1 □ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To After this 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending investigation within 24 hours after death To the Funeral Director: 2 Accident 1 ☐ Yes 2 ☐ No the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) Vormske MD RES-000 October 22 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pamela Danisse Singi Hospital of Baltimore 2401 W. Belvedere Ave Baltimore MD MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Rubinson, Victor

patient known os

			For State		State	of Mary		partment of ertificate of			lental Hy	_	-		
			Registrar  1. Decedent's Name (	First Middle	( ant)			er inicate or	Dean	11	2. Date of De	Reg. No.	20	08	3 3 9 5 2
н	Physici	an	1. Decedent's Name (	rirst, Middle,	Lasi)						Month	Day		Year	1:30 PM M
	/Medic		Dona Mari  4a. Facility Name (If n			umbarl		4b. City. Town.	or Locatio	on of Death	Octob			008 of Death	1:30 PM
	Examir	ier	Gilchrist				e Care	4b. Oky, lowin,						imore	
	Funeral		5. Social Security Nun		. Sex		n yrs. last birthda			er 24 Hrs.	8. Date of Bir	rth	art.	9. Birtho	ace (State or Foreign
	Director		190-58-63	316	1□M 2€ F		45 Yrs.	Months Days	Hours	s Min.	(Month, Da		3	Coun	rry)
	pc ,		Usual Residence of D	ecedent											Od Inside O'halisa'a
	arylar show		10a. State 1	0b. County		10	c. City, Town or	Location							0d. Inside City Limits 1 ☐ Yes 2 ☐ No
	Ba-f	Director	MD	Balti	more		Owings					1- 01			
	vith ti		10e. Street and Numb	er				10f. Zip Code				10g. Cit	izen ot v	Vhat Coun	try?
	s 23g	Funeral	133 Pleas	ant Hi	11 Rd.	and ant Five	rin D 4	21117		Origin3 (Pag	oifu Von or No	USA		e - Americ	on Indian
	item item	Ë	11. Marital Status 1 □ Never Married	1 of Marria	Armed F		rin 0.5.	<ol> <li>Was Decedent of If Yes, specify Cul</li> </ol>	ban, Mexic	can, Puerto	Rican, etc.)	,		k, White,	
336	72 hours after death with the Maryland natural", or items 23a or 28a-f show drail Evan, net it ust be notified	by	3 ☐ Widowed 4	•	If Yes, G	ive		1 ☐ Yes 2 ☑ No	Speci	ify:			Specify	Whi	te
ŏ	2 hou	ted	. 1	5. Decedent's	Education		16a. De	cedent's Usual Occu	pation			16b. Ki	ind of Bu	usiness/Ind	
21215-0036		Completed	(Specify Elementary/Second		grade completed College	) (1-4or 5+)	- (Gi	ve kind of work done  . DO NOT use retire	ed)	iost of workii	ng	Inc	dust	rial	Equipment
	e filed within al Hygiene. I other than '	Sol		, (,		4	Ser	ior Proje							
pu	be filed tal Hygi d other event, I	Be	17. Father's Name (Fi	irst, Middle, La	ast)				18. Mo	ther's Name	(First, Middle	, Maiden	Surnam	ie)	
yla	2 should be f and Mental is marked or aumatic eve	၉	Donald R	ay Sand	ers				-	tty Ja					
Maryland	2 short and rishmeria	- 0	19a. Informant's Nam				1	illing Address (Stree				-			•
e, 1	l and Health		Tim Reinh		band			3 Pleasan	t Hil		Owings			MD 2	
Jor	Pages 1 and 2 should be nent of Health and Ments ant: if Item 27 is marked ury or other traumatic e		20a. Method of Dispo 1 ☐ Burial 2 🖎	Cremation 3			cemetery, c	rematory or other pla	ace)		Oct 23			•	
Baltimore,	it. Pa irtmei irtant injury		4 □ Donation 5			346		eake Crema 22. Name and Addr			2008	Bel	Ltsvi	lle,	Maryland
Ba	permit. Page Department o Important: If any injury or once.		21. Signature of Fune	erai Service Li	rensee	W(0	Erri,	Cremation	and	Funera					
			23a. Part 1. Em r the	disease, or c	omplications that	caused the	e death. Do not	9717 Gree enter the mode of dy					imor	e, Ma:	Approximate
	Dharaisisa		shock, or heart Immediate Cause (Fi	failure. List or	nly one cause on	each line.					, ,				Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)		a. Due to		onsequence of):	COLON	MIN	CER					YEARS
T	Examiner				Dueto	Tor as a G	onsequence on.								
	_	Je.	Sequentially list condi- it any, leading to immo- cause. Enter Underly	itions,	b. Due to	Or as a co	onesquence of):								
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o,	e exe ian ai ırial-t	Ë	resulting in death) Las	st ,	Due to	o (or as a co	onsequence of):								
68760,	ficate be executed physician and s the burial-transit	edical		•	d										
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Вох	leath certific attending p	ian	23b. Was decedent p in the past 12 m			ebirth 2 🗀	Fetal death	3 Ectopic pregnar						te of delive inth	ery Day Year
P.O.	he de the a	Physician/M	1 □ Yes 2 🕱1 9 □ Unknown	No	4 □ Pre 9 □ Uni	gnant at tin known	ne of death	5 ☐ Other (specify)							
۳.	w requires that the de been signed by the should be detached	문	Part II. Other signification	ant condition	s contributing to	death but n	ot resulting in the	underlying cause g	iven in Pa	rt I.	23e. Did	tobacco ı	use cont	ribute to th	ne cause of death?
sp	uires 1 sign 1d be	d by									10	Yes 2	<b>⋈</b> No	3 ☐ Prob	pably 4 🗆 Unknown
00	w req	Completed									24a. Was	an	24h	Were auto	psy findings available
Re	he lav e has	广									auto	psy ormed?	!	prior to co death?	mpletion of cause of
ta	an: T tificat or, pe		25. Was case referred	d to medical					26 PI	ace of Death	1 ☐ Yes (Check only	2 No	<u> </u>	1 □ Yes	2 □ No
<u> </u>	ysick is cer direct	o Be	examiner? 1 ☐ Yes 2 🕱 No		Hospital: 1	Inpatient	2 🗆 ER/Outpa	tient 3 DOA Of	thor		me 5 ☐ Res		6 NOth	er (Specif	N HOSPICE
0	ding Physician: The I h. After this certificate hi funeral director, page	Ë	27. Manner of Death	s Clouding	28a. Dat	e of Injury onth, Day, Yo	28b. Time				28d. Describe		_		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
<u>i</u>	endir sath. or: Af he fur	atic	2 Accident	5 Pending investiga	tion				∃Yes 2	□No					
Division of Vital Records,	or Att ter de irecto n by t	Certification: To	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could no determin	20e. Plat	e of Injury ding, etc. (	- At home, farm, Specify)	street, factory, office		-	28f. Location ( City or To	Street an wn, State	nd Numb e)	er or Rura	l Route Number,
Ω	urs af urs af urai D			***											
	To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending from the Funeral Director. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	edical			xaminer: On the		amination and/o	eath occurred at the r investigation, in my							
	o the vithin o the omply	Me	29b. Signature and tit	le of certifier	and mo			29c. Licer	nse numbe	er	Т	29d. Da	ite signe	d (Month,	Day, Year)
	->-0			150	2/1	7	~	10/6	043	95		OCT	D Pan	R 22	,2008
	1	1	30. Name and addres	ss of person w	ho completed car	use of deat	h (Item 23a) (Tyr	e, Print)	-			/	·ev	21/	12008 MD 21204
	10	8 8	DANIEUR				656	5NOHAR	185	ST, 841	TE 209	BA	44711	norti	MD 21204
	Sta		31. Date filed (Month,			Registrar's						-			
	Registr	ar	0	CT 24	2008	Salarie.	, K	Charles							

DHMH 17 Rev 1/2001

Sanders, Dona

			1 State		artment of F	lealth and Me			
			Registrar  1. Decedent's Name (First, Middle, Last)	001	incate of L		. Date of Death	2008	3. Time of Death
	Physicia	an	Kenneth		tei-mer	_  ,	Month De toker	Day Year	= 19:39M
4	/Medic		4a. Facility Name (If not institution, give street and number)			Location of Death	16 COUCK	4c. County of Dear	
	Examin	ei	The Johns Hopkins Hospital		Baltimore	City			
	Funeral	100	5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday)	If Under 1 Year Months Days		. Date of Birth (Month, Day, Y	9. Bir Co	thplace (State or Foreign untry)
	Director		219-26-4464 12 M 2 G F	69 Yrs.	World Days	Tiodio With	07/04/	/1939 MD	
	pc. *		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	cation				10d. Inside City Limits
	laryla f sho	ō	MD Baltimore	Perry Ha					1 ☐ Yes 2 ☐ No
	the N	Director	10e. Street and Number	- Terry Ma	10f. Zip-Code		100	g. Citizen of What Co	untry?
	3a or	Ö	9608 Haven Farm Rd. Apt. L		21128			USA	
	ms 2	Funeral	11 Marital Status 12. Was Decedent Ev	ver in U.S. 13.	Was Decedent of H	lispanic Origin? (Speci an, Mexican, Puerto Ric	fy Yes or No-	14. Race - Ame	
9	or ite		Armed Forces?  1 □ Never Married 2 Married 1 → Yes 2 □ North 1 → Yes, Give	0	il res, specily cuba 1 □ Yes 2 X No	Specify:	Jan, etc.)	Black, Whit	e, etc.
3	ours ral", Exan	d by		1973-1975					ite
5	72 h 'natu dical	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of working		6b. Kind of Business Grocery S	•
V	within than than the Me	d L	Elementary/Secondary (0-12) College (1-4 or 5+	Mana		"		Grocery 2	core
V	Hygie rteri		12 17. Father's Name (First, Middle, Last)	Maria	yer	18. Mother's Name (	First, Middle, M	aiden Surname)	
2	d be	To Be	Kenneth O. Stermer			Nora Mor	gan		
	2 should be filed within 72 hours after death with the Maryland 1 and Mental Lygiene. 1s marked other than "natural", or items 23a or 28a-f show 1sumatic event, the Medical Examiner must be notified at	12	19a. Informant's Name/Relationship (Type. Print)	19b. Maili	ng Address (Street	and Number or Rural	Route Number,	City or Town, State,	Zip Code)
Ĕ	nd 2: alth a 27 is r trau		Joan V. Stermer/Wife	9608	B Haven F	arm Rd. Ap	t. L Pe	rry Hall,	MD 21128
Ď,	s 1 a of Heg		20a. Method of Disposition	20b. Place of Dispo	osition (Name of matory or other place	Dat	oct 2	Oc. Location - City or	Town, State
2	Page Tent of Tyor	111	1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)			tory Inc. 2		Beltsville	, Maryland
Daltillion	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Inmoortant: If them 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee		2. Name and Addre	ess of Facility and Funeral	Alterna	tives	
۵_	8 2 E 8 9		dy de Sue Retter		8717 Green	n Pastures D	rive Ba	altimore, M	aryland 21286
			23a. Part 1. Enter the disease, or complications that caused t shock, or heart failure. List only one cause on each line		ter the mode of dyli	ng, such as cardiac or	respiratory arres	st,	Approximate Interval Between Onset and Death
	hysician		Immediate Cause (Final disease or condition	consequence of):	5				Onset and Death
	/Medical Examiner		resulting in death)  Due to (or a a	consequence of):					
	Xaiiiiioi	ē	Sequentially list conditions,	consequence of):					-
	ed nsit	Examiner	Cause (Disease or injury	consequence on.					
	be executed ician and burial-transit		that initiated events	consequence of):					
9	ate be executed nysician and the burial-transit	dical	d						
00	The law requires that the death certificate the has been signed by the attending phys page 2 should be detached for use as the	Med					<del></del> :	1	
Š	n cert anding r use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of 1 ☐ Live birth		☐ Ectopic pregnanc	SV		23d. Date of de	
0	deatl e atte ed fo	sici	in the past 12 months?  in the past 12 months?  in the past 12 months?  in the past 12 months?  in the past 12 months?  in the past 12 months?  in the past 12 months?  in the past 12 months?  in the past 12 months?  in the past 12 months?  in the past 12 months?  in the past 12 months?  in the past 12 months?  in the past 12 months?  in the past 12 months?  in the past 12 months?		Other (specify)			Month	Day Year
5	v requires that the death certifica been signed by the attending ph should be detached for use as t	Phy	9 Unknown  Part II. Other significant conditions contributing to death but	it not resulting in the	underlying cause a	iven in Part I	23e Did tob	acco use contribute	to the cause of death?
ń	gned be d	þ	Tarti. Other significant conditions contributing to death but	it flot resulting in the	andonying dadoo g	TOTAL CO.	1 Tes		robably 4 🗆 Unknown
ecords,	requii sen s hould	Completed	-				24a. Was an	24h Were a	utopsy findings available
e e	e law nas b	ם					autopsy perform	ed? prior to death?	completion of cause of
			25. Was case referred to medical			26. Place of Death (		No 1 ☐ Ye	s 2 No
N I I	siclar certifi irectc	Be C	examiner?  1 \superset Yes 2 \times No Hospital: 1 Inpatien	nt 2 ER/Outpatier	nt 3 DOA Oth	or		ice 6  Other (Spe	ecify)
5	ting Physiclan: The law n	n: 7	27. Manner of Death 28a. Date of Injury	/ 28b. Time o		ry at 28		v injury occurred	
0	Attending Physiclan: It death. ector: After this certific by the funeral director,	atio	1 Natural 5 Pending (Month, Day 2 Accident investigation	Year) Injury		Yes 2 No			
<u>2</u>	I or Attendi after death. Director; A d in by the f	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide 28e. Place of injure building, etc.	ry - At home, farm, str (Specify)	reet, factory, office	28	If. Location (Str. City or Town,	eet and Number or F State)	Rural Route Number,
ב	italor irs affu al Dir led in	Ç						()	
	To the Hospital or Atteno within 24 hours after deatl To the Funeral Director: completely filled in by the	Medical	29a. Certifier (check only one)  1 **Certifying Physician: To the best of 2 **Medical Examiner: On the basis of and manner state on the company of the compa	examination and/or in					
	o the	Me	29b. Signature and title of certifier		29c. Licens			d. Date signed (Mon	P3
_	->-0		Detr M.O.		RES	-000		10-20-0	2008
	110		30. Name and address of person who completed cause of de	eath (Item 23a) (Type			1		
	811		Jin He M.	0.		600 N	orth Wolf	e St, Baltim	ore, MD, 21287
			21 Date filed (Month Day Vear) 32 Registrar	re Signatura	4/25				

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene 33954 Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death Month 3. Time of Death Day **Physician** Year Donald Lee Smith October: 5:05 A.M 22, 2003 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Genesis Crowell Center Baynesville Baltimore County 9. Birthplace (State or Foreign Country) AKron, Ohio 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 05,1925 **Funeral** 1X M 2□ F Months Hours 83 298-14-4982 Director Usual Residence of Decedent uld be filed within 72 hours after death with the Maryland Mental Hygiene. arked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f show event, the Medical Examination must be notified at 10d. Inside City Limits Director Baltimore County 1 ☐ Yes 2 No Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4201 Hollow Spring Lane 21236 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14∑Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2K Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No δ Specify: Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Social Security Elementary/Secondary (0-12) College (1-4or 5+) Claims Review Adminis. partment of Health and Mental Hyginortant; If Item 27 is marked other injury or other traumatic event, It 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Margiel Gayolia Dennis Percy Russel Smith Pages 1 and 2 should nent of Health and Men 19a. Informant's Name/Relationship (Type. Print) (Wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Althea Louise (nee Linnenbrogger) Smith 4201 Hollow Spring Lane Baltimore, MD. 21236 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Pages Department of Important; If it any injury or o 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Oct. 23, Evans Funeral Chapel 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, Maryland 2008 22. Name and Address of Facility
Peaceful Alternatives Funeral & Cremation Ctr., P.A.
2325 York Road Timonium, Maryland 21093 21. Signature of Funeral Service License 23a. Part 1. Enter the disease, r complications the shick, or lear failure. Ist only one cause of Lused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, seach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician NM4 cuncer /Medical Due to (or as a consequence of Examiner Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Chronic Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year signed by the a d be detached for 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? s certificate has t irector, page 2 s 24a. Was an autopsy perform 1 ☐ Yes 2 ☑ No 1 □ Yes 2 No filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 🗹 No Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 ☑ Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only one) within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 35274 10-24-08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HIRTARA 7505 OSTER SAINE, EVM Em mount 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

ORIGINAL

DHMH 17 Rev 1/2001

Division of Vital Records, P.O. Box 68760.

08-07802 Calvin Stokes

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

alvin Stokes		State of Maryland / Department of Hea - For State Certificate of Dea Registrar			201	08 3395
Physiciai ledical Examin	1/	L Decedent's Name (First, Middle,Last)		2. Date of Death	Day Year	3. Time of Death 1130 hrs
			Town, or Location of Death	October 10	4c. County of Dear	h 1
Funeral			more der 1 Year   If Under 24Hrs	. 8. Date of Birth	(MM/DD/YYYY) Ø. B	
Director		219-28-0355 1 MM 2 F 73 Yrs. Mon	ths Days Hours Min.	March	21,1935 C	ountry) Md.
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
Aaryland 28a-f show 1 at once	ē.	Md. NA Baltimo 10e. Street and Number 10f. Z	re Code	10	g. Citizen of What Co	1 Yes 2 No
the Mar a or 28s	Director	301 McMechen St. 1219	21217		USA	,
zeth with the Maryland items 23a or 28a-f sho ust be notified at once	uneral	1 Never Married 2 Married Armed Forces? If Yes, spe	dent of Hispanic Origin? ( Sp cify Cuban, Mexican, Puerto		14. Race - Ame White, etc.	rican Indian, Black,
after de	by Fu	or Dates:	2 No specify:		Specify: B	lack
72 hours n "natu			al Occupation (Give kind of working life. DO NOT use reting the second s		16b. Kind of Business	Andustry
5-0036 led within 7 Hygiene. I other than	Completed	17. Father's Name (First, Middle, Last)	er 18.Mother's Name	e (First, Middle, M	M.C. D	-ydock
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shumatic event, the Medical Examiner must be notified at once	8		unt Mai	ude	Stok	es
Battimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene Important: If item 27 is marked other than injury or other traumatic event, the Medical	٩	19a. Informant's Name/Relationship (Type, Print) Cousin 19b. Mailing Addre	SS (Street and Number or F	Rural Route Num	ve Balt	0, Md, 21215
ore, f es I and of Healt If item		20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from State crematory or other place.		Date	20c. Location - City of	or Town, State
Baltimore, permit. Pages I a Department of He Important: If ite	+		oreST 192	1/2008	Wwings 1	VIIIS, IVIA.
		23a. Pell Y. Enter the disease, or complications that caused the death. Do not enter the mod	WINCETA	une Ba	st shock or heart	Approximate Interval
Physician /Medical	10	tajure. List only one cause on each line.  Immediate Cause (Final disease a. Hypertensive Atherosclerotic Cardiovasc		, roop, alor,		Between Onset and Death
caminer		or condition resulting in death)  Due to (or as a consequence of):				
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause				
red Insit	Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
60, are be executed hysician and e burial - transit	dical	UNPENDED AMENDED				
18760, rtificate be ing physic as the bur	an/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal dea	h 3 Ectopic pregna	ancy	23d. Date of delive Month	ery Day Year
Box 6876 he death certificate the attending phy hed for use as the	Physician//	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Other (S)	necify)			
P.O. Es that the general by the detached	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying	ng cause given in Part I.	23e. Did to	bacco use contribute	o the cause of death?
ords, P.O.  v requires that the sbeen signed by t	eted			24a. Was a	an 24b. Were	autopsy findings available completion of cause of
of Vital Records, ag Physician: The law require. The thus certificate has been sineral director, page 2 should be	Completed			perfor 1 <b>Y</b> Yes	med? death?	
Vital Recysician: The Institute Inst	o Be (	25. Was case referred to medical examiner?  Hospital: 1 Inpatient 2 ER/Outpatient 3	26.Place of Death (Check		Residence 6 🗸 Oth	er: Scene
n of V ding Phy After th	⊢ŀ	27. Manner of Death  1 ✓ Natural  Natural  Natural  Natural  Natural  Natural  Natural  Natural  Natural  Natural  Natural  Natural  Natural  Natural  Natural  Natural  Natural	28c. Injury at Work?	28d. Describe h	now injury occurred	
Division pital or Attendir ours after death teral Director: A	Certification:	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factor				Rural Route Number, City
Div	Sert	4 Homicide determined (Specify)		or Town, S	·	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death To the Fineral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transil	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at one 2 Medical Examiner: On the basis of examination and/or investigation, in and manner stated.	ny opinion, death occurred	at the time, date	e(s) and manner as st and place, and due to	the cause(s)
Fara	ž	29b. Signature and title of certifier	9c. License number O.C.M.E.		29d. Date signed (A October 17, 20	
\ \	-	30. Name and address of person who completed cause of death (Item 23a)				
V\			eet, Baltimore, MD 21	1201		
Sta Registi	ite -	31. Date filed (Month, Day Year) 2008 32. Registrar's Signature				

			State of Maryland / Department of Health and N  1 - Registrar  Certificate of Death		2000	33956
			1. Decedent's Name (First, Middle, Last)	2. Date of Deat	eg. No. 4. U U ()	3. Time of Death
	Physici /Medi		Sharon F Smith	Month 10	2 <sup>Day</sup> 2008	1:40 M
we.	Examir				4c. County of Death	
**			l Jack Pine Place Parkville		Balto	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	8. Date of Birth (Month, Day,	9 Birth	place (State or Foreign
	Director		Usual Residence of Decedent	7-2	L-1961	MD
	yland Iow		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	a-fsh	tor	MD Balto Parkville			1 □Yes 2 No
	th the	Director	10e. Street and Number 10f. Zip Code	1	0g. Citizen of What Cou	ntry?
	within 72 hours after death with the Maryland iene. than "natural", or items 23a or 28a-f show he Maryland he mark item to the Maryland from the Maryland fr	<u>ra</u>	l Jack Pine Place 21236		USA	
	er der items	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White,	
36	rs aft	by F	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☐ No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:			Black
21215-0036	2 hou	ted	15. Decedent's Education 16a. Decedent's Usual Occupation		16b. Kind of Business/Ir	
2	hin 7.	ple	(Specify only highest grade completed)  (Give kind of work done during most of working the bound of the bound	ing		
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<u>\</u>	should I and Men s marke umatic	2	meddie Alston Beatr	ice Sau		
Mai	12 s thar 7 is trau		19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rura			
	s 1 and of Health item 27 other to		Carlton B. Smith-Husband   1 Jack Pine Place		.lle, Md 2	
õ	e = 5		1 Burial 2 Cremation 3 Removal from State		•	lstown, MD
altimore,			4 Donation 5 Other (Specify)  21. Signature of Funeral Service Lipensee  22. Name and Address of Facility		East F/H	ISCOWII/ IID
ñ	permit. Departi Import any Inj once.		Brank Miller 1101 E. North			MD 21202
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	Physician		Immediate Cause (Final disease or condition the cause of each line.	ardiala.		Interval Between Onset and Death
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ב	ital o urs aft ral Di lled ir	Š		City or Town,	,	
	To the Hospital or Attending Physician: The law requires that the death certifi within 24 horus after decert. The Fundus after decert. After this certificate has been signed by the attending, completely filled in by the funeral director, page 2 should be detached for use as	ica	29a. Certifier  (Check only one)  Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, a constant of the place of	and due to the ca	use(s) and manner as s	tated.
	ithin 2 the ormple	Medical	one) and manner stated.  29b. Signature) and title of certifier 29c. License number			
	+ ≥ ¥ 8		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		d. Date signed (Month,	2 -000
•		-	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		your c	1000
	り		FREDRIC IS STEHS MID- 7505 DS(EP De.	# 306 7	TOWSON MD	21204
	Stat	٠				
	Registra	r	OCT 2 4 2008			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 45 AM **EVELYN MAY STAIGERWALD** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner AIR Health + Re BOAIR Birthplace (State or Foreign Country) Social Security Number 6. Sex Age (In yrs. last birthday If Under 1 Year | If Under 24 Hrs 8. Date of Birth **Funeral** 218-22-4467 1 M 2 KF Months Davs Hours Min 94 Vrs Director June 21,1914 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Harford Bel Air - Harford County 1 ☐ Yes 2 X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1005 Winfield Drive 21015 USA Funeral Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, Black, White, etc. 1 ☐ Yes 2√XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 👿 No Specify þ Specify: 3€XWidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Supervisor of Registrars Johns Hopkins 12 yrs. N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Vogel Miriam Jones 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William D. Staigerwald (Son) 1005 Winfield Drive Bel Air, Md. 21015 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Gardens of Faith 10-24-2008 4 Donation 5 Dother (Specify) Baltimore, Md. Lassahn Funeral 7401 Belair Rd. 21. Signature of Funeral Service Licensee Home Baltimore, Md. 21236 F. Lassahr 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician QARS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 3 ☐ Probably 4 ☐ Unknown 1 Tyes certificate has been s rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perforn 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ 10 Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Mann Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 🖃 atural (Month, Day Year) 4 hours after death. Funeral Director: / 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 24 Robert & Dunch 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 615 NNO JA. 31. Date filed (Month, Day, Year) 62. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** SPANGLER GLADYS Month Yea 8 CAM /Medical 10 22 -08 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death HOSPICE OF THE CHESAPEAKE HOUSE LINTHICUM ANNE ARUNDEL 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign 1□ M 2 F Months Days Hours Min. 217.46.4612 93 UNITED KINGDOM Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County in than "natural", or items 23a or 28a-f show the Medical Examinant must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No ANNE ARUNDEL GLEN BURNIE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 140 SOUTH MEADOW DR. 21060 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2XX No Specify: 2 If Yes, Give Year or Dates: WHITE 3 Widowed 4 □ Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, Item Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) WILLIAM ARCHIBALD CONGDON 2 ELSIE GWENDOLINE KENDALI 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RODNEY M. SPANGLER SON 140 SOUTH MEADOW DR., GLEN BURNIE, MD 21060 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 3 Removal from State 4 ☐ Donation CROWNSVILLE VET. CEMETERY OCT. 28, 2008 | CROWNSVILLE, MD 5 ☐ Other (Spe of Juneral S 22. Name and Address of Facility FINK FUNERAL HOME, P.A. CREGO M01148 426 CRAIN HWY. S., GLEN BURNIE, MD 23a. Part 1. Buter the disease, shock, or heart failure. mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest In one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final **Physician** SEVERE DEMENTIA YEARLS disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. E. it or Underlying Cause (Disease or injury that initiated events southing in death). Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 5 ☐ Other (specify). signed by Part II**. Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Lunknown 24b. Were autopsy findings available prior to completion of cause of death? has 24a. Was an certificate 1 ☐Yes 2 ☐No 1 □Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 1 Yes 2 No ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) Certification: 27. Manner of Death After 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 No Director: d in by the 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide n 24 hours aft e Funeral Di detely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only the within ? 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CARLOS ZIGA SULTE 106 1406 S. CRAIN HWY, GLEN BURNIE M. D 31. Date filed (Month, Day, Year) #82. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year 0308 AM **Physician** 2008 TOBER MARGARET PICER /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner Baltimore City** The Johns Hopkins Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** Min. Months Days Hours 1 - M XXF 50 March 6,1958 Maryland **Director** 213-76-3954 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State show iral", or items 23a or 28a-f sho Examiner must be notified at 1 Yes X No Director MD Baltimore Owings Mills 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 21117 206 Stanlake Rd. U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No 11 Marital Status filed within 72 hours after 1 Never Married Married 1 □ Yes XXNo Baltimore, Maryland 21215-0036 er than "natural", or the Medical Examin Specify: If Yes, Give Year or Dates: Specify: White <u>چ</u> 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Mechanica1 permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me College (1-4 or 5+) Elementary/Secondary (0-12) Contractors Administrative Assistant 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Irvin Constantine Marion Ely မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Craig B. Spicer / Husband 206 Stanlake Rd. Owings Mills, MD 21117 20b. Place of Disposition (Name of cemetery, crematory or other place)
Maryland 20c. Location - City or Town, State 20a. Method of Disposition Date XXBurial 2 Cremation 3 Removal from State 10/29/08 Owings Mills, MD 5 Other (Specify) erans Cemetery 10/20/20 | 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 4 Donation 21. Signature of Furieral Service Licenses 11605 Reisterstown Rd. Owings Mills, MD21117 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** FADIOPULMONARY /Medical Due to (or as a consequence of): Examiner Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events Y. E. DAL FHILLURE Examiner Due to for as a consequence of aw requires that the death certificate be executed burial-transit EUKEMI HEL resulting in death) Last Due to (or as a consequence of): Box 68760, attending physician d for use as the buris Physician/Medical ANCER IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal dea 4 Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy Year in the past 12 months? Month Day 5 Other (specify) ate has been signed by the a page 2 should be detached t 2 15 No P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by of Vital Records. 2 MNo 3 ☐ Probably 4 ☐ Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 2 No certificate Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 M Inpatient Other: 4 \( \sum \) Nursing Home \( 5 \sum \) Residence 2 🗷 No 2 ER/Outpatient 3 DOA 6 Other (Specify) 1 ☐ Yes မ this filled in by the funeral 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of 27. Manner of Death al or Attending Pl s after death. il Director: After th Certification: (Month, Day Year) Division 5 Pending investigation Injury 1 Matural 2 □ No 1 TYes 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours af To the Funeral DI completely filled in 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier OCTOBER Z3 ZOO8 RES - 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 CHRISTINA NAMPW 32. **Re**gistrar's Signature 31. Date filed (Month, Day, Year) State 24 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible tamend items 10b,c per fh, 23pt.II per me g884 10-20-18 vt State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 10:27 PMM 2008 October 15, Sacktor 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Gilchrist Center for Hospice Care Towson Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign 6 Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year Months Days Min Hours 1 M 2 84 01/18/1924 NY 386-20-2936 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County N/A 1 ☐Yes 2 No **Baltimore** Baltimore Gity 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number 21209 USA 6502 Pimlico Rd. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Specify: 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Own Home Elementary/Secondary (0-12) College (1-4or 5+) Home Maker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Freda Abel Benjamin Charlton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Todd Sacktor/Son 7 Park Hill Place Yonkers, NY 10705 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Oct 16 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 2008 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mo 1443 Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, Maryland Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) PARKINSONS SARS Due to (or as a consequence of): TEICATION APPROVED BY MEDICAL EXAMINER Sequentially list conditions, it any, bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Disa to (or as a nonsectioned of) Melisca Brassetti Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 1 ☐ Yes 2 No 9 ☐ Unknown 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🕱 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? DEMENTIA 24a. Was an autopsy 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOS PICE Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No

/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit P.O. Box 68760, of Vital Records,

Division

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

show

ed other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at

filed within 72 hours after

Pages 1 and 2 should be

al Hygiene.

h and Mental F

permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 Is any Injury or other trau once.

**Physician** 

other traumatic

altimore, Maryland 21215-0036

June

10a.-State

MD

Director

Funeral

Completed by

Be

Examine Physician/Medical IF FEMALE: \$ Completed Be Certification: To

DIABETES 25. Was case referred to medical

Yes 2 No

27. Manner of Death 1 Natural

2 Accident 3 Suicide 6 Could not be determined 4 Homicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of cert

D64395

29d. Date signed (Month, Day, Year)

OCTOBER 16, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DANIEUE J. DOBERMAN. MD 6565 N CHARLES ST. SUITE 209 BALTIMINE, MD 21204

State Registrar

0

31. Date filed (Month, Day, Year)

24 2008 2. Registrar's Signature

			For State	State of I	Maryland		irtment of H <i>tificate of L</i>			lental Hy		Z 11117	3 3 3	961
			Registrar  1. Decedent's Name (First, Mid	idle, Last)		007	incate or i	Jean		2. Date of D			3. Time o	f Death
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Mary in a	Examir		4a. Facility Name (If not institut		er)		4b. City, Town, or	Locatio	n of Death		4c.	County of De		
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	Funeral		5. Social Security Number	6. Sex 7. 1 ☐ M 2 ☐ XF	Age (In yrs. las	t birthday) Yrs.	Months Days	Hours		8. Date of B (Month, D	ay, Year)		irthplace (State Country)	
	Director		Usual Residence of Decedent		/				1	Apr.	21, 1	193/1 WE	st Virg	ınıa
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	eath v	eral	1127 Shady Di	rive 12. Was Decede	nt Ever in U.S.	13. \	21040	ispanic (	Origin? (Sp	ecify Yes or N	US o-		nerican Indian,	
936	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygjene, item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Madical Evanting rust be notified at	by Funeral Director	1 ☐ Never Married 2 ☐ M. 3 ☐ Widowed 4 ☐ Divorce	Armed Force 1 ☐ Yes 2	s? XNo	1	Vas Decedent of H fYes, specify Cuba □ Yes 2∑TNo	Speci		Rican, etc.)		Black, Wh		
5-0036	72 hou	Completed		ent's Education		16a. Dece	lent's Usual Occup kind of work done o	ation	act of wark	ina	16b. Ki	ind of Busines		
2	thin 7 ne. nan "r	nple	Elementary/Secondary (0-12	hest grade completed)  College (1-4c	or 5+)	life. l	OO NOT use retired	iunny m i)	ost of work	ing				
21	led will her the her the		12	(- ( - A)		Hc	memaker <sub> </sub>	40 No	No o do Alono	/Eirot Middl		own Hon	e	
anc	l be fil intal H ed ot	Be	17. Father's Name (First, Middle)  James (NMN) S						_	e (First, Middle NMN) B				
Maryland	should nd Me mark matic	မ	19a. Informant's Name/Relatio			19b. Mailir	g Address (Street						. Zip Code)	
	alth ai 27 is r trau		Margaret L. I				Anglesea							2122
ē,	of Hee item rothe		20a. Method of Disposition		20b. Plac	ce of Dispo	sition (Name of natory or other plac	:e)	ı	Date	20c. Lo	ocation - City o	or Town, State	
Ē	Page ment of ant: If ury or		1 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other		ite i		Nat'l Ce		10/2	4/2008	Bal	Ltimore	, Maryl	and
Baltimore,	permit. Pages 1 and Department of Heal Important: If item 2 any Injury or other once.		21. Signature of Funeral Service	ce Licensee 2n R. WC	berCH	5P 22	Name and Address 1317 Coke							21009
			23a. Part 1. Enter the disease, shock, or heart failure. L.	or complications that causist only one cause on each	sed the death. h line.	Do not ent	er the mode of dyin	ıg, such	as cardiac	or respiratory	arrest,		Approxima Interval Be	te tween
-	Physician		immediate Cause (Final disease or condition	_a BREAS	T CANCE	R							Onset and	
-	/Medical Examiner		resulting in death)	Due to (or	as a conseque	nce of):								
н		ē	Sequentially list conditions, if any, leading to immediate	b Due to (or	as a conseque	nce of):							1	
4	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	4										
ر 0	an an rial-tr	Exa	resulting in death) Last	Due to (or	as a conseque	nce of):							1	
68760,	ate be hysici he bu	edica!		d									-	
39 ×	ertific ling p	Med	IF FEMALE:	1										
Вох	death certificate be executed e attending physician and d for use as the burlat-transit	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birt	me of pregnand h 2□Fetaid nt at time of dea	eath 3	Ectopic pregnanc	у			İ	23d. Date of o Month	lelivery Day	Year
0	0 O	ysic	1 ☐ Yes 2 ሺ No 9 ☐ Unknown	9 Unknow		XIII J.	Cirlei (specify)							
o.,	The law requires that the ate has been signed by th page 2 should be detache	by Pt	Part II. Other significant cond	litions contributing to deat	h but not resulti	ing in the u	nderlying cause give	en in Pai	rt I.	23e. Did	tobacco	use contribute	to the cause of	death?
rds	w requires s been sig should be	ed b								1 🗆	Yes 2	□No 3□	Probably 41	Unknown
ဝင္ပဝ	e taw re has bei je 2 sho	Completed								24a. Wa	s an opsy	24b. Were	autopsy findings o completion of	available
m.	The ate h	E O								per 1 □ Yes	formed?	death	? '_	00000
/ita	cian: ertific ector,	Be (	25. Was case referred to medie examiner?			-	T =		ace of Deat	h (Check only	one)		-	
of Vital Records,	ding Physician: The Ih. After this certificate hiteneral director, page		1 Yes 2 No		atient 2 El	R/Outpatier		4 🗆	Nursing Ho				pecify) HOSI	PICE
no	ding h. After funer	ion	27. Manner of Death  1X Natural 5 ☐ Pendings	ding 28a. Date of (Month, stigation	Day, Year)	Injury	Worl	yat k? Yes 2	П№	28d. Describe	now injui	ry occurrea		
Division	l or Attending after death. Director: After I in by the funer	fica	3 ☐ Suicide 6 ☐ Cou	ld not be 28e. Place of	injury - At hom	e, farm, str	eet, factory, office	103 2		28f. Location	(Street ar	nd Number or	Rural Route Nui	mber,
Ö	al or after	Certification: To	4 ☐ Homicide dete	building.	, etc." (Specify)					City or To	own, State	e)		
2	To the Hospital or Attenwithin 24 hours after deatt To the Funeral Director: completely filled in by the		29a. Certifier 1 Certif	ying Physician: To the be	est of my knowl	edge, deat	occurred at the tir	me, date	and place	and due to th	e cause(s	s) and manner	as stated.	(e)
9	the H nin 24 the F nplete	Medical	one) X Nurse I	Practit Tomer	stated.					Ted at the time				
	<b>5</b> wig <b>7</b> 00	2	29b. Signature and title of certi	itier	10		29c. Licens	e numbe	nda	2	29d. Da	ite signed (Mo	nth, Day, Year)	
	./		17XV	WOLKN		NO-1 (T	I K	14	7. 1			10/20	100	
	5		JACKIE JONES	on who completed cause of	· ·		LLEY RD.	ጥፐ፣	MONTI	M, MD 2	21002	1		
	Sta	ite	31. Date filed (Month, Day, Yea	ar) 32. Reg	istrar's Signatu	re A	DEL KU.	TT	TOMEO	rig EID 4	¢1033			
	Registi		DET 24 2	2008	istrar's Signatur									

12:45 а.ш.

OCTOBER 18, 2008

PEARLY MAY SHIPLEY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2000

			1 - State Registrar		,	Cer	tificate of L	Death		,	Reg. No.	2007	3 3 3 3 5 6
			1. Decedent's Name (First, Middle, Las	st)				-	2	. Date of De	ath Day	v Year	3. Time of Death
	Physicia /Medic		Satchithanandam	Subraman	iam				0	ctobe			9:05 A M
	Examin		4a. Facility Name (If not institution, giv	e street and number)			4b. City, Town, or	Location o	of Death		4c.	County of Dea	th
			10129 Ashburton	Lane			Beth	esda				Montgor	nery
	Funeral		5. Social Security Number 6. S		e (In yrs. last birt	hday)	If Under 1 Year Months Days	If Under	24 Hrs. 8 Min.	Date of Bir (Month, Da	th	9. Bir	thplace (State or Foreign ountry)
	Director		578-74-5924	<b>⊠</b> M 2□F	76	Yrs.	WOITINS Days	riouis		ugust 2			i Lanka
	ם ,		Usual Residence of Decedent		10 00 7								1.01.1.1.00.11.00
	show	<u></u>	10a. State 10b. County		10c. City, Town	or Loc	ation						10d. Inside City Limits
	Ba-f s	응	Maryland Montgo	nery	Bethe	esda							1 ☐ Yes 21 No
	or 28	Director	10e. Street and Number				10f. Zip Code				10g. Cit	izen of What Co	ountry?
	23a	<u></u>	10129 Ashburtor	Lane			2081	7			J	Jnited S	States
	ems	Funeral I	11. Marital Status	12. Was Decedent I Armed Forces?	Ever in U.S.	13. W	as Decedent of H Yes, specify Cuba	ispanic Ori	gin? (Speci	fy Yes or No	)-	14. Race - Ame Black, Whit	
õ	or it	F	1 ☐ Never Married 2 ☑ Married	1 ∐Yes 2 ☑ N If Yes, Give	10		□Yes 2⊠No	Specify:		. ,			Asian
200	ural"	d by	3 Widowed 4 Divorced	Year or Dates:								-	
ņ	72 h	Completed	15. Decedent's Ed (Specify only highest gra	lucation ide completed)	16a.	(Give k	ent's Usual Occup ind of work done o O NOT use retired	ation <i>Juring mo</i> st	t of working		16b. K	ind of Business	/industry
٧	vithin han	ш	Elementary/Secondary (0-12)	College (1-4or 5	+)						Tr.		Government
7	led v dygie her t		47 February News Asidala Land	5+		nes	earch Sc			First, Middle	1		overnment
yland	be find the	Be	17. Father's Name (First, Middle, Last)		1 - 4							,	
Š	ould Mel narke	2	Subramaniam Kar									anagarat	
2	2 sh n and ris n		19a. Informant's Name/Relationship (		- 1		Address (Street						
ฮ์ ขั	and lealth m 27 her t		Puvaneswary Satchi	thanandam/W			9 Ashbur						
ב ס	ges 1 t of 1 if ite or ot		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐	Removal from State	20b. Place of cemeter	Dispos y, crem	ition (Name of atory or other plac	(e) O	Dat ctobe		20c. Lo	ocation - City or	Town, State
altimor	men mant: lury		4 ☐ Donation 5 ☐ Other (Specif		Montgome	•	rematorium	, Inc.	200	08			Maryland
<u>a</u>	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If teem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exemitme transit be inclined at once.		21. Signature of Funeral Service Licer	isee		Roh	Name and Address	ss of Facility	Y Fimera	1 Home/	Bethe	eda-Chev	y Chase, Inc.
_	20 E # 9		foun K. Da	nnhank	M01546	755	7 Wisconsi	n Aven	rue Be	thesda,	Mar	yland 2	0814-3501
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that caused	the death. Do n	ot ente	r the mode of dyin	ng, such as	cardiac or	respiratory a	ırrest,		Approximate Interval Between
× F	Physician		Immediate Cause (Final disease or condition			omv	osarcoma					- 1	Onset and Death 19 Years
	/Medical		resulting in death)	a	a consequence of								
	Examiner			h									
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter of uniforming Cause (Disease or injury that initiated events	Due to (or as	a consequence o	of):							
/	cuter nd ransi	Examiner	Cause (Disease or Injury that initiated events	C.									
5	an an rial-t		resulting in death) Last	Due to (or as	a consequence o	of):							
00/00	eath certificate be executed attending physician and for use as the burial-transit	Medical		d									
0	tifica ng ph as th	led											
Š	h cel endir use		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy 2  Fetal death	ء ٦	Ectopic pregnance				}	23d. Date of de	livery
٥	deat e att d for	icis	in the past 12 months? 1 □Yes 2 □ No	4 Pregnant a			Other (specify)	у			ĺ	Month	Day Year
5	uires that the de signed by the a id be detached f	Physician <sub>2</sub>	9 ☐ Unknown	9 ☐ Unknown									
٠,	s tha ined e det	by P	Part II. Other significant conditions of	ontributing to death be	ut not resulting in	the un	derlying cause give	en in Part I.		23e. Did	tobacco t	use contribute to	the cause of death?
cords,	quire in sig ald bi	d b								1 🗆	Yes 2	Ñ No 3 □ P	robably 4 🗆 Unknown
ဥ	w rec	Completed								24a, Was	an	24b. Were a	utopsy findings available
ב ב	he la e ha ige 2	m								auto	psy ormed?	death?	utopsy findings available completion of cause of
ומ	n: T ificat or, pa		QE Man anno referred to medical							1 🗆 Yes	2 🖾 No	1 □Yes	s 2□No
5	Attending Physician: The law requir ardeain. Are this certificate has been s by the funeral director, page 2 should	Be	25. Was case referred to medical examiner?	Hospital:			3 Drog Othe	or:		Check only			
5	Phy r this ral di	<u>ا:</u>	1 Yes 2 No 27. Manner of Death	28a. Date of Inju	ent 2 ER/Out	ime of	28c. Injur	4 🗀 Nu		d. Describe		6 ☐ Other (Spe	ecify)
5	ding h. Afte fune	io	1 ☑ Natural 5 ☐ Pending	(Month, Da	y, Year) Ir	njury	Work	(?¨`` Yes 2 □ I		d. Describe	now injur	y occurred	
2	dear ctor the	ica	3 ☐ Suicide 6 ☐ Could not be		ırv - At home far	m etra		163 2		f Location (	Ctmeton	ad Number or D	ural Route Number,
2	ii or Attend after deail Director din by the	Certification: To	4 ☐ Homicide determined	building, etc	(Specify)	111, 5010	ct, lactory, office		20	City or To	wn, State	e)	urar noute rvamber,
	pours a constant of the consta		29a. Certifier 1 N Certifying Ph	ysician: To the best	of my knowledge	death	occurred at the tir	me date an	nd place ar	nd due to the	carreole	and manner a	e stated
	To the Hospital or Attending Physician: The law requires that the death or within 24 hours after death. After this certificate has been signed by the attend completely filled in by the funeral director, page 2 should be detached for us.	ledical	(Check only 2 Medical Exar	niner: On the basis o and manner sta	f examination and	d/or inv	estigation, in my o	pinion, dea	th occurred	at the time	date and	d place, and du	e to the cause(s)
i	To the Hos within 24 ho To the Fun completely	Med	29b. Signature and title of certifier	-	0		29c. Licenso	e number			29d. Da	te signed (Moni	th, Day, Year)
_	- s - ō		Not 1	1			nno	43361					
•	0	1	30. Name and address of person who	completed cause of d	oath (Itam 32c) /	Time D		1000			oct	tober 22	2, 2.000
	10		Robert S. Siegel,					nie. N	J.W #	13-428	W-	shingto	n, D.C. 20037
	Sta	to	31. Date filed (Month, Day, Year)		ar's Signature	<i>y</i> <u>_</u> • • • •	427 151.	1		720	W CI	.01111116 00	11, 11,0, 2003/
	Registr		OCT 2 4 200		M. A.	France	35						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#18, perFH, G884, 10/28/08, WS
State of Maryland, Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death October 21, 2008 **Physician** Katherine Stamatelatos 5:28 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Dec. 19 5. Social Security Number 7. Age (la ys. last birthday) 9. Birthplace (State or Foreign **Funeral** Year) 1 □ M 2 🗓 F Months Days Hours Min Romania 071-36-6590 Dec. 1918 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be netified at once. 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🖾 No Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 130 Chevy Chase Street #404 20878 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🔀 No Specify: ģ 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Costume Designer Theatre 18. Mother's Name (First, Middle, Maiden Surname)

Vasilica Fetresco 17. Father's Name (First, Middle, Last) Be ( Nicholas Ionescu ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael G. Stamatelatos/Son 12520 Bridgeton Drive, Potomac, Maryland 20854 20b. Place of Disposition (Name of cemetery, crematory or other place)
Park Lawn Memorial
Park 20a. Method of Disposition 20c. Location - City or Town, State October 25, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Rockville, Maryland 2008 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850 21. Signature of Funeral Service Licensee 23a. Part 1. End the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. M01498 Approximate Interval Between Onset and Death 2 Days Immediate Cause (Final disease or condition resulting in death) Respiratory Failure Physician /Medical Due to (or as a consequence of): Examiner Shock 2 Days Sequentially list conditions, if any, leading to immediate cause. Enter the critical Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director; After this certificate has been signed by the attending physician and Sepsis 2 Davs Due to (or as a consequence of): Physician/Medical IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day Year 5 ☐ Other (specity) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 □Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

P.O. Box 68760 Division of Vital Records. within 24 hours a To the Funeral D

> State Registrar

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier (Check only one)

4 Homicide

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Daphne Stamos-Keshishian, M.D. 9901 Medical Center Drive, Rockville, Maryland 20850

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

31. Date filed (Month, Day, Year) 32. Registrar's Signature

5 ☐ Pending

investigation

determined

6 Could not be

the Sparte

1 □Yes 2 □ No

58112

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

OCTOBER 21 2008

08-07943 Hozier Todd Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ozier Todd State of Maryland / Department of Health and Men  1- For State Certificate of Death	2008 3398
Physician/ 1. Decedent's Name (First, Middle,Last)	Reg. No.  2. Date of Death  Month  Day  Year  OQ40 bro
ledical Examiner Hozier Todd	October 22, 2008
4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location 2742 Baker Street Baltimore	of Death 4c. County of Death
Talleral	er 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign
Director         214-64-7475         1X м 2 F         50         Yrs.         Months Days         Hours	s Min. 11-7-1957 Foreign Country) MD
Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
<b>8</b> 1	1XXYes 2 No
Purple of the pu	10g. Citizen of What Country?
MD N/A Baltimore  10e. Street and Number  10e. Street and Number  2742 Baker Street  21216  11. Marital Status  12. Was Decedent Ever in U.S.  13. Was Decedent of Hispanic Ori	USA
The second secon	
The second of th	the state of the s
15. Decedent's Education (Specify only highest grade completed) 15. Decedent's Usual Occupation (Give during most of working life. DO NOT	kind of work done 16b. Kind of Business/Industry use retired)
18. Decedent's Caucation (Specify only highest grade completed)  18. Decedent's Caucation (Specify only highest grade completed)  18. Decedent's Caucation (Specify only highest grade completed)  18. Decedent's Caucation (Specify only highest grade completed)  18. Decedent's Caucation (Specify only highest grade completed)  18. Decedent's Caucation (Specify only highest grade completed)  18. Decedent's Caucation (Specify only highest grade completed)  18. Decedent's Caucation (Specify only highest grade completed)  18. Decedent's Caucation (Specify only highest grade completed)  18. Decedent's Caucation (Specify only highest grade completed)  18. Decedent's Caucation (Specify only highest grade completed)  18. Decedent's Caucation (Specify only highest grade completed)  18. Decedent's Caucation (Specify only highest grade completed)  18. Decedent's Caucation (Specify only highest grade completed)  18. Decedent's Caucation (Specify only highest grade completed)  18. Decedent's Caucation (Specify only highest grade completed)  18. Decedent's Caucation (Specify only highest grade completed)  18. Decedent's Caucation (Specify only highest grade completed)  18. Decedent's Caucation (Specify only highest grade completed)  18. Decedent's Caucation (Specify only highest grade completed)  18. Decedent's Caucation (Specify only highest grade completed)  18. Decedent's Caucation (Specify only highest grade completed)  18. Decedent's Caucation (Specify only highest grade completed)  18. Decedent's Caucation (Specify only highest grade completed)  18. Decedent's Caucation (Specify only highest grade completed)  18. Decedent's Caucation (Specify only highest grade completed)  18. Decedent's Caucation (Specify only highest grade completed)  18. Decedent's Caucation (Specify only highest grade completed)  18. Decedent's Caucation (Specify only highest grade completed)  18. Decedent's Caucation (Specify only highest grade completed)  18. Decedent's Caucation (Specify only highest grade completed)  18. Decedent's Caucation (Speci	Disabled
The state of the s	r's Name (First, Middle, Maiden Surname)
No de Paris de la Compania del Compania de la Compania de la Compania del Compania de la Compania del Compania del Compania de la Compania de la Compania del C	rothy Worthy mber or Rural Route Number, City or Town, State, Zip Code)
○ 역원:## 「	st Road BALTO, MD 21206
20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from State  Comparison Forest  20b. Place of Disposition (Name of cemetery, crematory or other place)  Garrison Forest	Date 20c. Location - City or Town, State
20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from State  4 Donation 5 Other Specify:  21. Signature of Funeral Service Licensee  22. Name and Address of Facility  22. Name and Address of Facility	10-29-08 Owings Mills, Md
21. Signature of Funeral Service Licensee  22. Name and Address of Facility  1101 E. Nor	March East F/H th Avenue Balto, MD 21202
Physician  23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as the failure. List only one cause on each line.	cardiac or respiratory arrest, shock, or heart  Approximate Interval  Between Onset and
xaminer Immediate Cause (Final disease a. Hypertensive Atherosclerotic Cardiovascular Disease	Death
or condition resulting in death)  Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of): cause. Enter Underlying Cause	
(Disease or injury that initiated events resulting in death) Last  C.  Due to (or as a consequence of):	
d.  AMENDED  AMENDED  AMENDED  AMENDED	
	23d. Date of delivery
OB To specify the past 12 months?  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  If FEMALE: 23b. Was decedent pregnant in the past 12 months?  If FEMALE: 23b. Was decedent pregnant in the past 12 months?  If FEMALE: 23b. Was decedent pregnant in the past 12 months?  If FEMALE: 23b. Was decedent pregnant in the past 12 months?  If FEMALE: 23b. Was decedent pregnant in the past 12 months?  If FEMALE: 23b. Was decedent pregnant in the past 12 months?  If FEMALE: 23b. Was decedent pregnant in the past 12 months?  If FEMALE: 23b. Was decedent pregnant in the past 12 months?  If FEMALE: 23b. Was decedent pregnant in the past 12 months?  If FEMALE: 23b. Was decedent pregnant in the past 12 months?  If FEMALE: 23b. Was decedent pregnant in the past 12 months?  If FEMALE: 23b. Was decedent pregnant in the past 12 months?  If FEMALE: 23c. If yes, outcome of pregnancy  1 Live birth 2 Pregnant at time of death 5 Other (Specify) 9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Females.	ic pregnancy Month Day Year
Other (Specify)	
ে দুর্ঘ ক্রিট্র 🗖 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in P	
9 (= A   7	1 Yes 2 ✔ No 3 Probably 4 Unknown  24a. Was an 24b. Were autopsy findings available
toord law received the set of the	autopsy prior to completion of cause of death?
Construction of the set of the se	1 V Yes 2 No 1 V Yes 2 No
The spiral 1 Inpatient 2 ER/Outpatient 3 DOA Outlet 4	Nursing Home 5 Residence 6 ✔ Other: Scene
27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Wor	/ ′ ′
2 Accident Investigation 28e Place of Injury - At home farm street factory office building a	
1   Natural   5   Pending   Investigation   2   Accident   1   Yes 2   2   Accident   2   Accident   3   Suicide   6   Could not be determined   Could not be determin	or Town, State)
2 A Certifying Physician: To the best of my knowledge, death occurred at the time, date and p (Check only one) 2  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death o	
and manner stated.  29c. License number  29c. License number	r 29d. Date signed (Month, Day, Year)
O.C.M.E.	October 23, 2008
30. Name and address of person who completed cause of death (Item 23a)  Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltim	nore, MD 21201
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar	

DHMH 17 Rev 1/2001 OCME 2006

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death a Ctober. **Edward Bruce Thomas** 4a. Facility Name (If not institution, give street and nun 4b. City, Town, or Location of Death 4c. County of Death Baltimore (17 N/A Grenera If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 9. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) . last birthday 1 □ M 2 □ F 218-60-3285 Mar 5, 1954 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ¥Yes 2 ☐ No **Baltimore** Maryland n/a 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1707 North Pulaski Street 21217 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∏Yes 2 ☐ If Yes, Give Year or Dates: 2 🗆 No 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify 3 ☐ Widowed 4 ☐ Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) University Hospital Domestic Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Catherine Braxton Sandy Dingles 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DeWayne Newman 1646 Ralworth Road Baltimore, Maryland 21218 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5 ☐ Other (Specify) 4 ☐ Donation uneral Service Line 22. Name and Address of Facility 21. Signature of Estep Brothers Funeral Service, P 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequ of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Dav Year 5 Other (specify) □Yes 2□No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 PNo 2 No 1 Yes 26. Place of Death (Check only one) Hospital: 2 **1**No

**Physician** /Medical Examiner

permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiens Important: If item 27 is marked other that any Injury or other traumatic event, Its once.

**Physician** 

/Medical

Examiner

**Funeral** 

Director

show

ir than "natural", or items 23a or 28a-f show the Medical Examinar is ust by retified at

Director

Funeral

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Completed

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the Maryland

Baltimore, Maryland 21215-0036

attending physician for use as the burial sate has been signed by the page 2 should be detached

Examine Completed by Physician/Medical Be

A B To the Hospital or Attending Physician: The law requires that the death certificate be exec nores after death.

neral Director: After this certificat
y filled in by the funeral director, pr Medical Certification: To

Division of Vital Records, P.O. Box 68760,

e Funeral within 24 hor To the Fune completely f

State Registrar

25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∏Yes 1 / Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred (Month, Day, Year) 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number MD 30. Name and address of person who completed cause of death (Item 23a) 32 Registrar's Signature 31. Date file (Month, Day, Year) 2008 4 **ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Andrew Thompson	1- For State Registrar	tate of Maryland	d / Departme <i>Certifica</i>			Mental H	Re	g. No.	008 3396
Physician/ Medical Examiner	Decedent's Name (First, Mid-     Andrew	dle,Last) Thompsor				- 114	Date of Death     Month     October 21	Day Year	3. Time of Death 2211 hrs
4	4a. Facility Name (if not instituti					ocation of Death		4c. County of	
	716 208th Street	6. Sex 7.	Age (In yrs. last birtho		adena nder 1 Year	Killnder 24Um	le Date of Birt	Anne Arui	9. Birthplace (State or Foreign
Funeral Director	5. Social Security Number 215-40-4247	1 X M 2 F		Mor	nths Days	If Under 24Hrs Hours Min			Country)
	Usual Residence of Decedent	X M 2 F	66	Yrs.			12/2	3/1941	MD
y any	10a. State 10b. County	,	10c. City, Town or	Location					10d. Inside City Limits
f show	4	Arundel				sadena			1 Yes 2 X No
e Mary or 28a ied at	10e. Street and Number 716 208th St	root		10f. 2	Zip Code	21122	10	g. Citizen of Wha	•
vith the s 23a c a notifi	11. Marital Status	12. Was Decede	ent Ever in U.S.	13. Was Dece	edent of Hispa		pecify Yes or No-		SA American Indian, Black,
leath v r item nust be		Married Armed Force				Mexican, Puerto		etc.	
trail Records, P.O. Box 68760,    State   Completed by Physiciani/Medical Examiner   Completed by Physiciani/Me	3 X Widowed 4 D	vorced If Yes, Give Year	2 <u>X</u> 110	1 Yes	2 X No	specify:		Specify:	White
hours natur Exam	15. Decedent's Education (Sp	, , , , , ,	dı			n (Give kind of v DD NOT use reti		16b. Kind of Busi	
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5-00 ed with tygiene other in	17. Father's Name (First, Middle	e, Last)		nain			e (First, Middle, N	faiden Surname)	
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D 2'should should Mand Mand Maric et Is mz	19a. Informant's Name/Relation Tracey Kelley	ship (Type, Print )						ber, City or Town,	
and 2 and 2 fealth a tem 2 traum	20a. Method of Disposition		20b. Place of			etery,	Date	Burnie, A	Dity or Town, State
TOFE ages 1 int of H it: If i	1 Burial 2 X Crematic		State Cremator	y or other pla		0c	t. 23 2008	Baltima.	co Marriland
altiry or my or	4 Donation 5 Other 3		Inecto		nd Address o	of Facility			re, Maryland
ini in De a	Mischelf	Stalle	is	3111	Mount	ain Rd,	Pasader	s Funera. na, MD 21	l Home, P.A. L122
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	Immediate Cause (Final diseas or condition resulting in death)	e a. Atheroscleroti	c Cardiovascula	r Disease					Death
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Xam xam	(Disease or injury that initiated events resulting in death) Last	Due to (or as a co	nsequence of):				<del></del>	· · · · · · · · · · · · · · · · · · ·	
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tal F	25. Was case referred to medic examiner?	Hospital:				of Death (Check			
f Vi Physi er this ral dir	1 ✓ Yes 2 No 27. Manner of Death	28a, Date of I		me of Injury	DOA 28c. Injury			Residence 6 🗸	
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Visic or Atte fter dee Directo in by th		estigation 28e. Place o	Injury - At home, fan	m, street, facto	ory, office bui	ilding, etc.			or Rural Route Number, City
Direct Filled	4 _ Homicide det	ermined (Specify)					or Town, S		
he Ho in 24 h he Fu pletely	Chook only	Physician: To the best of aminer:On the basis of e							
To t vith To t	29b. Signature and title of certif	and manner state			29c. License				(Month, Day, Year)
	Cleck	e Hall	0110		O.C.M	I.E.		October 22,	2008
	30. Name and address of person							l	
		ssistant Medical Ex		enn Stree	t, Baltimoi	re, MD 2120	)1		
State Registrar		32. Regis	trar's Signature	6					

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		_	1 - For Amend Registrar	Iten 2:	State of Ma ns 23aPtI, BaPtI,II p	er d	7,28a- r. Ceri	timent of the tificate of	jeagyang Death	1586 (155%)	Reg. No.			
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P.W.			JOHNS HOPKI	INS	BAYVIEW	MED	ICALCEN		BALTIM					
	Funeral Director		5. Social Security Number 214-26-0168	6. Se 1 [	x 7. Age ☐ M 2☐ F 7		ast birthday) _ Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		rth a <i>y, Year)</i> 20 <b>,</b> 19	9. Bird Co Ma:	thplace (State or Foreign ountry) ryland	
	w w		Usual Residence of Decedent 10a. State 10b. Cour	ntv		10c City	, Town or Loc	ation					10d. Inside City Limits	_
	/anyle	ō		,	11		lersvil						1 □ Yes 2 No	
	the N	Director	MD Anne  10e. Street and Number	Aru	nder	MTTT	reisvii	10f. Zip Code			10g. Citiz	en of What Co	puntry?	-
	h with		8250 Carters	Lane				21108			USA			
ဖွ	be filed within 72 hours after death with the Maryland at Hygiene.  do thygiene.  do ther than "natural", or items 23a or 28a-f show event, the Medical Examinating the rediffical at	Funeral	11. Marital Status 1 □ Never Married 2 □ N		12. Was Decedent B Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give			/as Decedent of H Yes, specify Cub □Yes 2X No	Hispanic Origin? (San, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)		4. Race - Ame Black, White		
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Maryland 21215-0036	la la		19a. Informant's Name/Relation			se		,	and Number or R					
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Division of	I or Attending Physician: after death. Director: After this certific. d in by the funeral director,	Certification:	3 ☐ Suicide 6 ☐ Cou	ald not be ermined	28e. Place of Inju- building, etc <b>Unknown</b>	iry - At hoi :. (Specify	me, farm, stre	et, factory, office		28f. Location	(Street and wn. State)	Number or R	ural Route Number,	-
	To the Hospital or Atte within 24 hours after de To the Funeral Directo gompletely filled in by th	Medical C	29a. Certifier 1 Certific (Check only one)	ying Phy cal Exam	rsician: To the best of the state of the sta	examinat	wledge, death tion and/or inv	occurred at the ti estigation, in my	me, date and plac opinion, death occ	ce, and due to the curred at the time	cause(s) , date and	and manner a place, and due	s stated. e to the cause(s)	
	To the	Me	29b. Signature and title of cert	ifier				29c. Licens	se number		29d. Date	signed (Mont	th, Day, Year)	7
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	(13)		30. Name and address of pers							. ~				
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	-	For State Registrar	State of Marylan	-	artment of rtificate of			Reg. No.	フロロス		
ysici: /ledic	an al	Decedent's Name (First, Middle, Las- Harry Vanvalin     Aa. Facility Name (If not institution, give			4b. City, Town,	or Location of	2. Date of I Month 10/24	4/200	Year 8 County of Deatl	6:21	of Death
amin eral	CI	Stella Maris H 5. Social Security Number 6. Se	ospice	as <i>t birthd</i> ay) Yrs.	Timoni If Under 1 Year Months Days	um If Under 2		Ba	1timor		e or Foreig
	tor	Usual Residence of Decedent  10a. State 10b. County  MD	10c. City	y, Town or Lo	e City		77 800 07	1,20		10d. Inside	City Limit
ust be notil	ral Director	10e. Street and Number 600 Light St.			10f. Zip Code 21230	)		10g. Citi	zen of What Co	untry?	
or other traumatic event, the Medical Examinar must be notified at	by Fu	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 Myes 2 □ No If Yes, Give Year or Dates:1944	-53	1 □Yes 21 No	Specify:	in? (Specify Yes or Puerto Rican, etc.)		14. Race - Amer Black, White Specify:Whi	te.	
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Jury		Evelyn Dodd/Co  20a. Method of Disposition  1 Burial 2 Cremation 3 4 Donation 5 Other (Specify  21. Signature of Euneral Service Licen	Removal from State	lace of Dispo emetery, crea	osition (Name of matory or other pl	ace)	Pittsfo Date 0/28/08 CAFA/Ste	20c. Lo	ocation - City or	Town, State	) D. P.
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fune	Certification:	1 Natural 5 ☐ Pending 2 ☐ Accident 3 ☐ Sulcide 4 ☐ Homicide 5 ☐ Could not be determined	(Month, Day, Year)	Injury ome, farm, st	M 1	ork? □Yes 2□N	No 28f. Location		nd Number or Re	ural Route N	'umber,
completely filled in by the	Medical C	(Check only 2☐ Medical Exam	nysician: To the best of my kno niner: On the basis of examina tital orner stated.	wledge, dea ation and/or i	nvestigation, in my	time, date an y opinion, dea nse number	d place, and due to th occurred at the tir	ne, date an	and manner a d place, and due te signed (Mont	to the cause	
ō		29b. Signature and title of certifier	11.10		290. Lice	i o o o	2	250. Da	io digrico (Nont	, Day, 10a1,	,

DHMH 17 Rev 1/2001

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6:21

OCTOBER 24, 2008

HARRY VANVALIN

9 Completed Be Certification:

attending physician for use as the buria signed by the Hospital or Attendi 24 hours after death. Funeral Director: A To the Hospital of within 24 hours af To the Funeral D

23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contribu ath but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tyes No 3 Probably 4 □Unknown 24a. Was an Were autopsy findings available prior to completion of cause of autopsy death? 1 🗌 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 1 Yes 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) 1 ☐ Inpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner etated.

29c. License number

12:20 P<sup>M</sup>

North Carolina

White

10d. Inside City Limits

Approximate Interval Between Onset and Death

4-202

29d. Date signed (Month, Day, Year)

1 ☐ Yes 2 ➡No

death.

State Registrar Linda Freilich

nd title of certifier

29b. Signature a

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 101 Wheel Road, Bel Air, MD 21014

32 Registrar's Signature 31. Date filed (Month, Day, Year)

OCT 2 4 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-07907 State of Maryland / Department of Health and Mental Hygiene 33970 Barbara Ann Weigand Certificate of Death Rea. No. 1- For State Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Month Day October 20, 2008 Physician/ 2121 hrs Barbara Ann Wiegand Medical Examiner Ac County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Harford **Bel Air** 1807 Woodhome Drive 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 24Hrs. If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** Min. Country) MD Months Davs Hours 12-29-1954 53 Director 2X F Vrs М 215-68-4781 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State any 1 Yes 2X No Bel Air or 28a-f show Harford 23a or 28a-f show notified at once. Pages 1 and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene.

Int. If item 27 is marked other than "natural", or items 23a or 28#f sho 10g. Citizen of What Country? Director 10f Zip Code 10e. Street and Number USA 21015 1807 Woodhome Dr 14. Race - American Indian, Black, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Funeral 11. Marital Status White, etc. Armed Forces? 2 X Married Never Married Yes 2 X No Specify: White Yes 2 X No specify: If Yes. Give Year Divorced Widowed 16b. Kind of Business/Industry Examiner 16a. Decedent's Usual Occupation (Give kind of work done þ 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) Own Home the Medical Homemaker 21215-0036 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Hartley Louis Otremba it: If item 27 is marked other traumatic event, Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) 1807 Woodhome Drive Bel Air, MD 21015 Thomas Wiegand (Husband) Baltimore, MD 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) . Cremation 3 Removal from State 1 X Burial 2 10-25-2008 Bel Air , MD BelAir Mem. Gardens Donation 5 Other Spec 22. Name and Address of Facility Schimunek Funeral Home of BelAir nature of Funeral Service 610 W. MacPhail Rd Bel Air, MD 21014 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and the disease, of Physician failure. List only one cause on each line Death 'Medical a. Contact Gunshot Wound of Head Immediate Cause (Final disease aminer Due to (or as a consequence of): or condition resulting in death) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been simpled to the formal formula to the fine of the formula to the fine of the formula to the fine of  $_{
m X}$  AMENDED 1 per me g884 10-24-08 vt hysician/Medical UNPENDED attending physician or use as the burial 23d. Date of delivery Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE: Day Month Year 3 Ectopic pregnancy 23b. Was decedent pregnant in the Fetal death Live birth past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 V Unknown has been signed by the att 2 should be detached for g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. Yes 2 ✓ No 3 Probably 4 Unknown ģ 24b. Were autopsy findings available Completed 24a. Was an prior to completion of cause of autopsy death? performed? certificate has b 1 🗸 Yes 2 No Yes 26.Place of Death (Check only one) 25. Was case referred to medical Be Residence 6 🗸 Other: Scene Other<sub>4</sub> Hospital: Nursing Home 5 examiner? DOA ER/Outpatient 3 Inpatient 2 1 V Yes No ۵ 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) FOUND: 28c. Injury at Work? 28b. Time of Injury 27. Manner of Death Subject shot self Certification: FOUND: Yes 2 V No Natural Pending Director: 2110 hrs Oct 20, 2008 28f. Location (Street and Number or Rural Route Number, City Investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 1807 Woodhome Drive, Bel Air, MD 3 V Suicide Could not be (Specify) Single Family Home 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier October 21, 2008 O.C.M.E. 30. Name and a dress of person who completed cause of death (Item 23a)

Registrar

DHMH 17 Rev 1/2001

OCME 2006

State

Ling Li, MD

31. Date filed (Month, Day, Year

Assistant Medical Examiner

2008

32. Registrar's Signature

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 20a per fb g884 10-24-08 bt. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month 6:35 AM Christian George Wild, Sr. 10 2008 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Gilchrist Center

6. Sex Baltimore Maryland
If Under 24 Hrs. 1 rowson, Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 07/06/1933 7. Age (In yrs. last birthday) 5. Social Security Number Days Hours Months 1**X** M 2□ F Maryland 75 215-28-7268 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County 1 ☐ Yes 2 No Kingsville Baltimore MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21087 U.S.A. 1 Darney Court 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status Armed Forces? 1 ☐ Yes 2 No 1 □Yes 2 X If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yes 2X No Specify: 3 X Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Plumbing Industry 9 Plumber 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Anna Pearl Whittle Christian Gotlieb Wild 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 21234 19 Kintore Court - Baltimore, Maryland Bruce J. Wild (son) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Tother (Specify Entombment Gardens of Faith Cem. 10/25/2008 | BAltimore, Maryland 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 21. Signature of Funeral Service Licensee 11750 Belair Road - Kingsville, Maryland 21087 assaln 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final nenter veno ( Stuge disease or condition resulting in death) Due to (or as a consequence of): Deripheral Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): in betes Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 9 I Inknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 □Yes 2 ☑ No 2 🗆 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) pice 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifie

physician al s the burial-t Physician/Medical attending p for use as use as the detached 2 Completed been funeral director, Be Certification: To

**Physician** 

/Medical

**Examiner** 

Funeral Director

Completed by

Be

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Examiner

**Funeral** 

Director

Department of Health and Mental Hygiene. In portrain: Pages 1 and 2 should be filed within 72 hours after death with the Maryland. Department of Health and Mental Hygiene. Important: if time 27 is marked other than "natural" or the properties of

**Physician** 

/Medical

Examiner

Box 68760,

P.O. I

Division of Vital Records,

tran and

requires that the death certificate be executed signed by t. I be detache certificate has briector, page 2 sl After this To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral

Medical

31. Date filed (Month, Day, State Registrar

29b. Signature and title of certifier

(Check only

and manner stated.

29c. License number

29d, Date signed (Month, Day, Year)
Olfbu ZZ, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6701

32. Registrar's Signature

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death oľtober°zı, žůba **Physician** 11:30FM NICHOLAS WOLNIAK /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Baltimore 4b. City, Town, or Location of Death Examiner Center If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral Months Days Hours Min. 1**∑X**M 2□ F 94 INDIANA Director 105.01.9707 DEC. 20, 1913 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location r than "natural", or items 23a or 28a-f show the Wedeal Even increust be notified at 1 ☐ Yes XXX No Director BALTIMORE HUNT VALLEY 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number by Funeral 9 SILENT MEADOW COURT 21030 death 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No If Yes, Give Ye ar or Dates: WW I I Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 and 2 should be filed within 72 hours after Health and Mental Hygiene.
em 27 is marked other than "natural", or ite ther traumatic event, the Medical Exprints. 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify WHITE Specify: 3XXWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MAIL CARRIER POSTAL SERVICE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MATTHEW WOLNIAK SOPHIE SKERPAN ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MATTHEW WOLNIAK SILENT MEADOW COURT, HUNT VALLEY, 21030 item 27 other t MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 J<sub>o</sub> permit. Pages Department of Important: If its any injury or o 1 XXBurial 2 ☐ Cremation 3 XXRemoval from State ONONDAGA VALLEY CEMETERY | OCT 27, 2008 4 ☐ Donation 5 ☐ Other (Specify) SYRACUSE, NY 21. Signatur Funeral Service Li 22. Name and Address of Facility
FINK FUNERAL HOME, P.A. FINK M01148 426 CRAIN HWY. S., GLEN BURNIE, MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or co eplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, cheart failure. List only one cause on each line. Immediate Cause (Final ISCHEMIC COLITIS DAYS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner VOLUME DEPLETION DAYS Sequentially list conditions, if any, loading to initiodate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed CONGESTIVE HEART FAILURE YEARS attending physician and for use as the burial-trar Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Day 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No sate has been signed by the page 2 should be detached in 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, δ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 □ Yes 2 No 1 ☐ Yes funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) t Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Date of Injury (Month, Day, Year) 27. Manner of eath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation after death.

Director: Ald in by the fur 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide within 24 hours a Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation. In my opinion, death occurred at the time, date and place and due to the cause(s) and manner as stated. 29a. Certifier Medical completely (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 22/08 D37254 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) POH LIM. 7601 OSLER DRIVE TOWSON, MARYLAND 21204 NOOS 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Registrar

Baltimore, Maryland 21215-0036

Box 68760,

P.O.

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 2008 October /Medical 4a, Facility Name (If not institution, give street and number County of Deat City, Town, or Location of Death edica **Examiner**  Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 11/28/1937 Age (In yrs. last birthday Social Security Number **Funeral** Days 1 □ M 2 🗹 F 213-36-1226 70 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits 10a State 10b. County 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the "nation Examination in a feet for the control of the control o 1 ☐ Yes 2 No Director MD Anne Arundel Curtis Bay 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1509 Cypress Street 21226 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑No Baltimore, Maryland 21215-0036 Specify: Specify: ģ 3 ☐ Widowed 4 ☑ Divorced White permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. In Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exposes. Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Punte Margaret Baumer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 95 Will-O-Brook Drive, Pasadena, MD 21122 Donna Waters/Daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) ■Burial 2 □ Cremation 3 □ Removal from State Cedar Hill Cemetery 10/21/08 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility G.J. Gonce Funeral Home, PA 21. Signature of Janeral Service Licensee 169 Riviera Drive, Pasadena, MD 21122 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Menman disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 124 Sequentially list conditions, if any, leading to him red cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) ne Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Exami Due to (or as a consequence of): Box 68760-Physician/Medical IF FEMALE: 23c. If ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown in the past 12 months? 3 Ectopic pregnancy Month Year 5 ☐ Other (specify) signed by the at d be detached fo P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, ģ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy certificate 2 oxod 2**/**0 No Dia 1 ☐ Yes 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to midical examiner? Be 26. Place of Death (Check only one 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of De th 1 Natural 2 Accident 28b. Time of 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Division 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ess of person who completed cause of death (Item 23a) (Type, Print) 17 32. Registrar's Signature 31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death October 21,2008 **Physician** Robert. Zawadowicz John 1:29  $A^{M}$ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center Baltimore Towson 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral X** M 2□ F Months Days Hours Min 152-50-8896 53 Director Passaic, NJ. Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State ral", or items 23a or 28a-f show Exercises reust be notified at 1 Yes 2 No Director Maryland Harford Jarrettsville 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 3949 Madonna Road 21084 USA Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🔀 No þ Specify: White 3 Widowed 4 Divorced r than "natural", the Medical Exe Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 years College (1-4or 5+) Owner Vending Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, II once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Bejamin Zawadowicz Ruth Josephine Willard ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3949 Madonna Road, Jarrettsville, Maryland Cathy Zawadowicz wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State October 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Oak Lawn Cemetery 24, 2008 Dundalk, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service License Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease shock, or heart failure. e, or complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest List only one cause on each line. Immediate Cause (Final Physician 0 MISTATO leans disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infine date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) physician and s the burial-transi Due to (or as a consequence of): attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Feta! death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy certificate 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check onl one) 1∐Yes 2⊡No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA After this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation ours after death.

leral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, within 2.

1- Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29d. Date signed (Month, Day, Year) October 21, 2008 29b. Signature and title of certifier 29c. License number

State Registrar

Medical

31. Date filed (Month, Day, 2008

(20

BINC N. Charl 6701 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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ZollickasFer

			1 - State of Maryland / Department of State of Maryland / Department of Certificate		R	eg. No. 4 U U (	3 33977
	Physicia		1. Decedent's Name (First, Middle, Last) Hildegarde Clara Aubrey		2. Date of Deat October	8 Day 2008 Year	3. Time of Death 7:43P M
	/Medic Examin			wn, or Location of G		4c. County of Dea	
	Funeral Director		5. Social Security Number  153-28-6875  6. Sex  1 M 2 R 7. Age (In yrs. last birthday)  Months D  Months D		Min. De Month Day,	, <sup>Ye</sup> ¶'935 Nev	thplace (State or Foreign
	Maryland a-f show	tor	Usual Residence of Decedent  10a. State				10d. Inside City Limits 1 □ Yes 2 ★No
	with the	Funeral Director	10e. Street and Number 10f. Zip Co 9904 Braddock Road 209		1	0g. Citizen of What Co USA	ountry?
330	be filed within 72 hours after death with the Maryland that Hygiene. cd other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be redified at	by Funer	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ☑ No If Yes, Give Year or Dates:		n? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Ame Black, Whit Specify:	
215-0036	na"	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	Occupation done during most o retired)	f working	16b. Kind of Business.	
7	filed wit Hygien sther th ent, the	Co	12 Secretary	19 Mothor's	Name (First, Middle, M	U.S. Gove	rnment
	d be fi ental F ked ot c ever	To Be	17. Father's Name (First, Middle, Last) Fritz Woellner		Barbara Ze		
Mary	nd 2 should be filed within alth and Mental Hygiene. 27 is marked other than ir traumatic event, the M	ř	19a. Informant's Name/Relationship (Type. Print)  Sandra Marie Aubrey/ Daughter 9904 Brad		or Rural Route Number		
baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev once.		20a. Method of Disposition  1	of or place) oc 20	t. 20,	20c. Location - City or Arlington	
Dall	permit. Departi Importa any Inji once.		21. Sign, Aire of Funeral Service Licensee 22. Name and A Francis	Address of Facility  J. Coll versity	ins Funeral Blvd, W, S:	l Home, Ind ilver Sprin	c. ng, MD 20903
	Physician		23a. Part 1. Enter the disease, or cor plications that caused the death. Do not enter the mode of shock, or heart failure. List only on a cause on each line.  Immediate Cause (Final disease or condition		ardiac or respiratory arr	est,	Approximate Interval Between Onset and Death  2 months
	/Medical Examiner		disease or condition resulting in death)  a. <u>Myelodysplastic Syndrom</u> Due to (or as a consequence of):	162			
	Laummer	e.	b. Acute Myeloid Leukemia				1 month
00,00	rificate be executed g physician and as the burial-transit	al Examiner	Sequentially list conditions, if a y, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Acute Myelola Leukemia Due to (or as a consequence of):				
00	rtificate ng phy as the	/ledical	IF FEMALE:				
O. BOX	To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death within 24 hours after death. To the Luneral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use.	Physician/N	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 ▼No 9 □ Unknown  23c. If yes, outcome of pregnancy  1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy  4 □ Pregnant at time of death 5 □ Other (special pregnancy)			23d. Date of de Month	elivery Day Year
rds, r.	quires that the substant of th	ρ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause	se given in Part I.		bacco use contribute t es 2 <b>⊠</b> No 3□ P	o the cause of death?
II Records,	The law recate has bee	Completed			24a. Was a autops perform	med? prior to death?	
VII	sician; certific rector,	Be	25. Was case referred to medical examiner?  Hospital:	Othor:	f Death (Check only on		
0 10	nding Phy th. : After this funeral di	Certification: To	1 Yes 2 No   Tospital: 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death   28a. Date of Injury (Month, Day, Year)   28b. Time of Injury   28c. Injury   28c. Time of Injury	Injury at Work? 1 ☐ Yes 2 ☐ No		ow injury occurred	ecity)
DIVISION	al or Atter s after dea I Director d in by the	ertifica	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, factory, of building, etc. (Specify)	ffice	28f. Location (St City or Town	treet and Number or R n, State)	tural Route Number,
	ne Hospit: n 24 hours ne Funeral	Medical C	29a. Certifier  (Check only one)  1 ★ Certifying Physician: To the best of my knowledge, death occurred at 2 Medical Examiner: On the basis of examination and/or investigation, in and manner stated.	the time, date and my opinion, death	place, and due to the coccurred at the time, d	ause(s) and manner a late and place, and du	e to the cause(s)
	To th Comp	Me	29b. Signature and title of certifier 29c. L	icense number		9d. Date signed (Mon	
	10		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		186	10/09/2	20307
			Terrence Pyle (900 Georgia A)  31. Date filed (Month, Day, Year)  32. Registrar's Signature	re. No	, wash	ington	C 20307
	Sta Registra		OCT 1 0 2008 Februar 18 April				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State RegistAMEND#23e, 24aperMD10/10/08, EWW, MDCo Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Vear nne M. Anzelone 10 2008 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Hillhaven Nursing Center, Inc. Adelphi Prince George's If Under 1 Year | if Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Months Days Hours 1 □ M 2 🝊 F Vrs 200-20-6236 July 24, 1924 Pennsylvania Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 ☐ Yes 2 ☐ No Maryland Prince George's Laurel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 7700 Cherry Lane, #325 20707 USA 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 🗷 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify 3 X Widowed 4 ☐ Divorced White 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Receptionist Florist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Michael Protz Anna Verosky 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2491 Emmanuel Court, Huntington, MD 20639
Disposition (Name of Date 20c. Location - City or Town, State Patricia A. Curl/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Oct. 14, 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 2008 Gate of Heaven Cemetery Silver Spring, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility
Francis J. Collins Funeral Home Inc. 500 University Blvd, W., Silver Spring, MD 20901 23a. Part1. Eller the disease, or complications that called the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) Cardiac Arry Kimin 5 mins Due to (or as a consequence of) Coronary Heart dise se Fibrillation Scuutially lit moditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due toyer as a consequence of): Diabetes Mellitus IF FEMALE: 23c. if yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectonic pregnancy Month Year Day in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hemibhegia Right Side 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes 2 No Dementia 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 No 1 🗌 Yes 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

permit. Pages 1 and 2 should be filed within 72 hour Department of Health and Mental Hyglene. Important: If item 27 Is marked other than "natural" any injury or other traumatic event, the Medical Expone. Physician /Medical Examiner Examiner Physician/Medical

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

ral", or items 23a or 28a-f show Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after conent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or iter

Baltimore, Maryland 21215-0036

Director

Funeral

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Be Completed

Medical Certification: To

29a. Certifier (Check only one)

The law requires that the death certificate be executed funeral director. this I hours after death.

Uneral Director: Al
ely filled in by the fu within 24 hours after

To the Funeral Dire

completely filled in by

Records, P.O. Box 68760,

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier wohn 29c. License number D17843 29d. Date signed (Month. Dav. Year) 10 6/2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

VIVERC VAIDM. D3311 Toledo Terrace + Bloz Myattsvillo Md. 20782

State Registrar 31. Date filed (Month, Day, Year) OCT 1 0 2008

08-07730 Andrew Akpar Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

drew Akpa	n	1	State of Maryland /	Department <i>Certificate</i>	t of Health and Mental H <u>y</u> e <i>of Death</i>	ygierie Reg. I	200	18 3397
Phys	icia		egistrar . Decedent's Name (First, Middle,Last)		0.200	Date of Death     Month Date		3. Time of Death
edical Exa		er		CPAN		October 13,	2008	2137 hrs
		4	ta. Facility Name (if not institution, give street and number) Shady Grove Hospital		4b. City, Town, or Location of Death Rockville		4c. County of Death Montgomery	
Fune	ral			e (In yrs. last birthday	y) If Under 1 Year If Under 24Hrs	. 8. Date of Birth (I	MM/DD/YYYY) 9. Birti	nplace (State or Foreign
Direct			219-55-1079 1 XM 2 F	36	Yrs. Months Days Hours Min	OCT 10		ntry) RRA LEONE
			Usual Residence of Decedent					10d. Inside City Limits
w any			10a. State 10b. County	10c. City, Town or L				1 Y Yes 2 No
Maryland	fied at once.	ٳۊؚ	MONTGOMERY  10e. Street and Number	SILVER S	SPRING I 10f. Zip Code	10g.	Citizen of What Cour	try?
ne Mar	fied a	Ë	1812 GREENWICH WOOD DRIVE	# 12	20903		USA	
with th	o not	Funeral Director	11. Marital Status 12. Was Decedent	Ever in U.S. 13	B. Was Decedent of Hispanic Origin? ( S If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - Ameri White, etc.	can Indian, Black,
death or iten	must	<u>.</u>		X No		radan, day		A CIV
s after	. 91	اھ	Widowed 4 Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade cor		1 Yes 2 X No specify: cedent's Usual Occupation (Give kind of	work done	Specify: BI  6b. Kind of Business/l	ACK
2 hour	Examin	eted	Elementary/Secondary (0-12) College (1-4 or	duri	ng most of working life. DO NOT use ret			
036 ithin 72 are.	ledical	omple	12ТН	1	NURSE ASSISTANT		PRIVATE	
215-0036 be filed within 7 ntal Hygiere.	the M	ပ၂	17. Father's Name (First, Middle, Last)			e (First, Middle, Mai HANSON	iden Surname)	
more, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Montal Hygeline was 10 Health and Montal Hygeline was 10 Health and worled other than "natural", or items 23a or 28a-f Site wit. I frem 23a or 28a-f Site	or other traumatic event,	To Be	ANTHONY M. AKPAN  19a. Informant's Name/Relationship (Type, Print )	19b. N	Mailing Address (Street and Number or		er, City or Town, State	, Zip Code)
MD on 2 show	umatic		ANTONIA M. AKPAN/SISTER		12 GREENWICH WOOD	DR # 12 S	ILVER SPRI	NG,MD 20903
re, legal Fred Fred Fred Fred Fred Fred Fred Fred	er tra		20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from SI	tate crematory	or other place)		20c. Location - City or	
Pages nent o	or oth		4 Donation 5 Other Specify:	GEORGE	WASHINGTON CEME 1			
Baltimore, MC permit. Pages 1 and 2 s Department of Health at	njury		21 Signature of Funeral Service Licensee		22. Name and Address of Facility J 7474 LANDOVER RO		INS FUNERA	
Physic	_	4	23a Part I. Enter the disease, or complications that caused	the death. Do not e				Approximate Interval Between Onset and
'Medi	cal		failure. List only one cause on each line.  Immediate Cause (Final disease a. Cardiac a.	arrhythmia	1			Death
, camii	ileid		or condition resulting in death) Due to (or as a cons		aly with myocardit	ie ecarri	no	
	н	-	if any, leading to minediate Due to for as a cons		ity with myocardit.	IB BEATTE	<u> </u>	
		Examiner	cause. Enter Underlying Cause (Disease or injury that initiated execute resulting in death). Last	sequence of):				
nted	- transit		d d			127700 7		
e exec	sıcıan and burial - tra	edical	X UNPENDED AMENDED	. line a-b	,2/,perNE, g884 10	TEMEN NO CH	¥.	
760, ficate be	g physi	/Me	F FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outco	ome of pregnancy	Fetal death 3 Ectopic pregi	nancy	23d. Date of deliver Month	y Day <b>Ye</b> ar
Box 6876 death certificate	the attending phy hed for use as the b	Physician/M	past 12 months?	at time of death 5	Other (Specify)			
Bo.	the at	hys	1 Yes 2 No 9 Unknown 9 Unknown	th but not resulting i	n the underlying cause given in Part I.	23e. Did tob	acco use contribute to	the cause of death?
P.O.	gned by detach	ð	Part II. Other significant conditions contributing to dea	ar but not resulting in	, and an activity in great and a second	1 Yes	2 No 3 Pro	bably 4 🗸 Unknown
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of Vital Records,	icate has t	ldm				perform	ned? death?	es 2 No
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Vit.	this ce	To Be	examiner?  1 V Yes 2 No Hospital: 1 Inpat				Residence 6 Other	er:
n of	After		27. Manner of Death  1 X Natural 5 Pending	JUTY ,Year)	me of Injury 28c. Injury at Work?	Zod. Describe in	ow injury occurred	
Division ral or Attendi	by the	icati	2 Accident Investigation 28e. Place of	Injury - At home, farr	n, street, factory, office building, etc.			ural Route Number, City
Division ospital or Attent hours after death	teral Director: After this certification of the funeral director,	Certification:	3 Suicide 6 Could not be determined (Specify)			or Town, Sta	ate)	
H 42	Fun		29a. Certifier 1 Certifying Physician: To the best of one) 2 Medical Examiner: On the basis of ex	my knowledge, death	n occurred at the time, date and place, a restigation, in my opinion, death occurred	nd due to the cause d at the time, date a	e(s) and manner as sta and place, and due to t	ited. he cause(s)
To the within	To the comple	Medical	29b. Signature and title of certifier	1.	29c. License number		29d. Date signed (M	
2.	2	_	Caral Haro.	NIA	O.C.M.E.		October 14, 200	08
-			30. Name and address of person who completed cause of	death (Item 23a)				
			Carol Allan, MD Assistant Medical Exa	aminer 111 P	enn Street, Baltimore, MD 212	201		
D	S egis	tate trar	OOT 9 1 Zillis &	rar's Signature				

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #20a-c Per FH G885 11/19/08 JH State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** Ramona Burguillo Oct. 7. 2008 1630 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth 2/10/1924 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🕅 F Months Days Hours Puerto Rico 84 125-24-9033 Director Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, he the field standard rust be notified at N.Y. Bronx Bronx Director 1 X Yes 2 ☐ No the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 1340 Stratford Avenue 10472 USA Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after or Hygiene. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ∐Yes 2 □ No þ Puerto Rican Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Clothing Factory Seamstress 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and 2 should be Jesus Aviles Luisa Evia 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20910 permit. Pages 1 and 2 s Department of Health a Important: If Item 27 is any Injury or other trau once. 25 E. Wayne Avenue #810 Silver Spring, Md Issa L.Burguillo/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date remation 3 □Removal from State Chesapea 10/2008 <u>-</u> 10/11/2008 <del>Seltsville,Md</del> Silver Spring ,Md 4 □ Donatio 5 ☐ Other (Specify HeavenCemetery 21. Signature of Funeral Service L PHYTTE TO Address RIMALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cardiopulmonar arrest /Medical Due to (or as a consequence of) Examiner Anoxic encephalopathy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last be executed Exami Severe bronchio asthma and Due to (or as a consequence of) burialphysician the burial 68760 Physician/Medical certificate attending p for use as t Box IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) the Ö 9 Unknown signed by the ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? of Vital Records. þ 1 ☐ Yes 2 A No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy page ( The perform 1 ☐ Yes 2 X No 1 Yes Physician: 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2X No this 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending Division 1 Natural 5 Pending investigation death. М 1 ☐ Yes 2 ☐ No i Director: d in by the f 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 Homicide 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated To the I within 2 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D0063343 Oct.7,2008 30. Name and addr so of pason who completed cause of death (Item 23a) (Type, Print) 1500 Forest Irina Y.Ruban M.D. Glen Rd Silver Spring, Md20910 31. Date filed (Month, Day, Year) State 1 0 2008 OCT Registrar

DHMH 17 Rev 1/2001

			State of Marylar		artment of H rtificate of L			001	10	22001
			Registrar  1. Decedent's Name (First, Middle, Last)		tincate of L		2. Date of Death	3	18	3 J J O i
П	Physici						Month	Day \	/ear	3. Time of Death
a long	/Medi Examir		Zona May BINGAMAN  4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death	October	4c. County of	Death	
200			Washington County Hospital			rstown		Washi		2
	Funeral		<ol> <li>Social Security Number</li> <li>Sex</li> <li>Age (In yrs.</li> </ol>		If Under 1 Year Months Days		8. Date of Birth (Month, Day,		9. Birthpla Counti	ice (State or Foreign
H	Director		214-09-4409 1□ M 2\RF 88 Usual Residence of Decedent	Yrs.	Dayo	Tiodio IVIIII.	Feb. 12			1and
	land wo			ty, Town or Lo	cation				100	d. Inside City Limits
	Mary I-f sh	ţō	Maryland Washington	Had						1X Yes 2 □ No
	h the	Director	10e. Street and Number	пар	10f. Zip Code		10	g. Citizen of Wh	at Countr	
	th wit		910 Chestnut Street		217	740	ĺ	11	SA	,
	ems ems	Funeral	11. Marital Status 12. Was Decedent Ever in U. Armed Forces?	.S. 13. V	Vas Decedent of His f Yes, specify Cubar		pecify Yes or No-	14. Race	America	
36	filed within 72 hours after death with the Maryland Hygiene. wher than "natural", or items 23a or 28a-f show ant, the Midden Eyar in ar must be norithed at	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No	1	Yes 2 <b>X</b> No	Specify:	nicari, etc.)		White, et	o.
8	hours tural	g p	Year or Dates:					Specify:	Whi	te
5	in 72 " rai	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give I	lent's Usual Occupa kind of work done di DO NOT use retired)	uring most of work	ring 1	6b. Kind of Busi	ness/Indu	stry
212	l with giene.	E O	Elementary/Secondary (0-12) College (1-4or 5+)		Homemaker			Her own	home	
פ	e filec al Hyg othe vent,	Bec	17. Father's Name (First, Middle, Last)				e (First, Middle, M.		поше	:
<u>a</u>	should be fand Mental s marked of umatic eve	70	John Clayton Ruth			Nora Eli	zabeth H	olidav		
Jar	2 sho and is ma	, A	19a. Informant's Name/Relationship (Type. Print)	19b. Mailin	g Address (Street a				ate, Zip C	iode)
<u>გ</u>	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene.  If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Model Even in example mortified at		Eleanora M. Wiles - Daughter		White Hal		Hagersto	wn, Md.	2174	10
Ö	Pages 1 nent of h ant: If ite ary or ot		20a. Method of Disposition  1   Burial 2 □ Cremation 3 □ Removal from State	lace of Dispos emetery, crem	sition (Name of natory or other place	)	Date 2	Oc. Location - Ci	ty or Tow	n, State
Baltimore, Maryland 21215-0036	it. Pa rtmer rtant: njury		4 □ Donation 5 □ Other (Specify) Cec		m Mem. Pa		7/08 Н	agersto	wn, N	faryland
Вa	permit. Page Department Important: II any injury o		21. Signature of Funeral Service Licensee		Name and Address	1.1.7	nnich Fu			
			23a. Part 1. Enter the disease, or complications that caused the death	41	5 E. Wils	son Blvd.	Hagerst	own, Mar		
*	Thursinian .	0	shock, or heart failure. List only one cause on ach line.	i. Do not ente	r the mode of dying	, such as cardiac	or respiratory arres	št,	tr	pproximate nterval Between onset and Death
	Physician /Medical		disease or condition resulting in death)	A						
	Examiner		Due to (or as a consequ	rence or):					i.	
-	p .=	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Inderlying.	uence of):					-	
	ecute and transi	Examiner	cause, Enter Underlying Cause (Disease or injury that initiated events  c							
Ď,	be ex		resulting in death) Last  Due to (or as a consequ	ience of):		-				
00/00	ificate be executed physician and s the burial-transit	edical	d							
X	eath certifi attending for use as		IF FEMALE: 23b, Was decedent program 23c. If yes, outcome of pregnal	nev						
DOX	atter for u	ciar	in the past 12 months?	death 3 🗆	Ectopic pregnancy Other (specify)			23d. Date of Month		ay Year
5	by the	Physician/M	1 ☐ Yes 2 No 4 ☐ Pregnant at time of do 9 ☐ Unknown 9 ☐ Unknown	Jun 3 🗆	Other (specify)					
Ď.	w requires that the desired sheen signed by the should be detached	by P	Part II. Other significant conditions contributing to death but not resu	ilting in the und	derlying cause given	in Part I.	23e. Did toba	cco use contribu	te to the	cause of death?
ords,	equire en si	ed	ATMAC FIBRILLATION	<u> </u>			1 ☐ Yes	2 □ No 3[	Probab	ly Unknown
ັ້ນ .	has be	Completed					24a. Was an	24b. We	e autops	/ findings available
ב 	rnysician: The Is rthis certificate ha ral director, page 2	e l				<del></del>	autopsy performe 1 □ Yes 2 ¶	d? dea	r to comp th? Yes 2	letion of cause of
5	cran: sertific	Be (	25. Was case referred to medical examiner?			26. Place of Death	(Check only one)	2110	165 2	
5 8	this c	၉	1 ☐ Yes 2 No Hospital: 1 Inpatient 2 ☐ E			4 LI Nursing Hol	me 5 Residen	ce 6 Other	Specify)	
	After funer	ö	1 Natural 5 ☐ Pending (Month, Day, Year)	28b. Time of Injury	28c. Injury a Work?		28d. Describe how	injury occurred		
2	death death ctor: y the	icat 	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 380 Place of Injury. At hor	mo form atra-		es 2□No	201			
	after after Dire	Certification:	4 Homicide determined 28e. Place of Injury - At hor building, etc. (Specify,	)	et, lactory, office		28f. Location (Stree City or Town,	et and Number o State)	or Rurai A	oute Number,
4	3 3 5 5 1	- 1	29a. Certifier Chack poly	vledge, death	occurred at the time	e, date and place	and due to the care	se(s) and mann	er as stat	ed.
1	in 24 in 24 he Fu	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and manner stated.	ion and/or inve	estigation, in my opi	nion, death occurr	ed at the time, date	and place, and	due to th	e cause(s)
Ę	Vith Com	Σ	29b, Signature and title of certifier		29c. License r	number	29d	. Date signed (N	fonth, Da	v, Year)
		4			1205	5794	1	0-13	3 -0	90
.2	<i>U-, i</i>		30. Name and address of person who completed cause of death (Item		rint)		0	4 11.	1	21742
	14		1. Date filed (Month, Gay, Year) 32. Registrar's Signatu	11110	medic	al (ar	nous Ko	1. Hug	2/5to	un, mo
	State Registra	_		4 1						
		Registrar OCT 1 5 2008								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Celeste Lorraine Branyan Oct 6, 8:44 PM 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death St. Leonard Calvert 5364 Forest Trail If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, NOV 24 9. Birthplace (State or Foreign **Funeral** Year 952 Months Days Hours Min. 144-48-6392 1 □ M 2 🔀 F 55 Pennsylvania Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Calvert. St. Leonard Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
United States 20685 5364 Forest Trail Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: white 1 ☐ Yes 2 🔀 No Specify: 5 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) homemaker own hame 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Forest Rickert Zella Mayme Colburn 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Earl Branyan-husband 5364 Forest Trail St. Leonard, MD 20685 20b. Place of Disposition (Name of cemetery, crematory or other place) Oct 11 2008 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Buriat 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Port Republic Maryland Chesapeake Highlands Memorial Gardens 22. Name and Address of Facility Rausch Funeral Home 21. Signature of Funeral Service Licensee BRausch 4405 Broomes Is. Rd. Port Republic MD 20676 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ung cance rears /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) and burial-trai Due to (or as a consequence of) attending physician Physician/Medical the IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month 4☐Pregnant at time of death 5 ☐ Other (specify) Yes 2 No the 9 I Inknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 XYes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed: this certificate 2 **N**O 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No ٥ 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? after death. 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, Hospital or Attending Physician:

Maryland 21215-0036

Baltimore,

completely filled in by the funeral To the Hospital within 24 hours a To the Funeral D

State

Medical

29a Certifier

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

and manner stated

32. Registrans Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Amend 19b, FD, 10/14/0	, D	uchess, per , CCHD, drw Please	Type or Print in							egible.	
		For State Registrar	State of Maryla		artment ertificate			Mental H	ygiene Reg. No. 2	008	33983
Physicia /Medic		Decedent's Name (First, Middle, L     Frances Hasb	ast) rouck Broomfie	ld				2. Date of D Month	Death 10/09/2	2008 <sup>ear</sup>	3. Time of Death <b>04:11 19</b> 07
Examine		4a. Facility Name (If not institution, g. 416 Westlake I	Blvd.		Pri	ince	Location of Death Frederi	ck		ounty of Death Calvert	
Funeral Director		5. Social Security Number 6.  521–44–3561  Usual Residence of Decedent	Sex 7. Age ( <i>In yrs</i> 1	s. last birthday Yrs.		Year Days	If Under 24 Hrs. Hours Min,	8. Date of B	1932	9. Birthp Coul	place (State or Foreign CO
Maryland a-f show ified at	tor	10a, State 10b, County  MD Calve		City, Town or L		rick				1	0d. Inside City Limits 1 ☐ Yes 2 No
th with the 23a or 28a ust be not	al Director	10e. Street and Number 416 Westlake	Blvd.		10f. Zip C		20678		_	of What Cour	ntry?
1215-0036 within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married 3 □ Widowed 4 ☒ Divorced	12. Was Decedent Ever in I Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	U.S. 13.	Was Decede If Yes, specif 1 ☐ Yes 2		spanic Origin? (Sp n, Mexican, Puert Specify:	pecify Yes or No Rican, etc.)		Race - Americ Black, White, pecify: Wh	
215-00 thin 72 hou e. an "natura Medical E.	Completed	15. Decedent's I (Specify only highest g	/ Education	16a. Dece (Give life.		done d retired)	luring most of wor )	king		of Business/In	dustry
und 21. be filed with that Hygien dother the	Be	17. Father's Name (First, Middle, Las George Hasbro	4 (t)		Resea	arch	18. Mother's Nam	ne (First, Middle y Rache	le, Maiden Su	,	arch
Maryla 4 2 should th and Mer 7 is marke	욘	19a. Informant's Name/Relationship	(Type. Print)	1			and Number or Ru	ral Route Num	ber, City or T	own, State, Zip	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		Lynne Krause/Da  20a. Method of Disposition  1 □ Burial 2 X Cremation 3    4 □ Dogation 5 □ Other (Spec	20b.  Removal from State	Place of Disposemetery, cre	osition (Name ematory or oth	e of ner place		unting Date .0/2008	20c. Locat	ion - City or To	own, State
Balti permit. Departir Importa any Inju		21. Signatur of Funeral Service Lice Lisa M. Mon	ensee	2	2. Name and	Addres		ee Fune	eral Ho	ome Cal	vert, P.A.
Physician /Medical Examiner		23a. Part1. Enter the disease, or cor shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death)	nplications that caused the deal y one cause on each line.  a	ler	iter the mode			or respiratory	arrest,		Approximate Interval Between Onset and Death
ecuted and -transit	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consect.  Due to (or as a consect.)								
Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome pf pregr 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3[	⊒Ectopic preç ⊒ Other <i>(spec</i>	gnancy cify)			23d	. Date of delive	ery Day Year
cords, P.O. w requires that the debeen signed by the should be detached	୍ର	Part II. Other significant conditions	contributing to death but not re	sulting in the u	inderlying cau	ise give	n in Part I.				ne cause of death?
al Reco	Completed							perl	s an 2 opsy formed? 2 XNo	prior to con death?	psy findings available mpletion of cause of 2 No
or VIta ng Physician ter this certifi neral director	n: To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No  27. Manner of Death	Hospital: 1 Inpatient 2  28a. Date of Injury (Month, Day Year)	ER/Outpatier		Othe	4 LI Nursing Ho		sidence 6		y)
or Attendir or Attendir after death. Director: At in by the fur	Certification:	1 Natural 5  Pending investigation 3  Suicide 6  Could not to determined	De 290 Place of injury At h	nome, farm, sti	М	1 □ Y	es 2□No	28f. Location City or To	(Street and Nown, State)	lumber or Rura	l Route Number,
le Hospital 124 hours a le Funeral I	Medical Ce	29a. Certifier (Check only one)  1 Certifying P 2 Medical Exa	hysicían: To the best of my kn míner: On the basis of examin and manner stated.	owledge, deat ation and/or ir	th occurred at ovestigation, in	the time	e, date and place, binion, death occur	and due to the	e cause(s) an e, date and pla	d manner as si ace, and due to	tated. the cause(s)
To the within To the composition of the composition	Me	29b. Signature and title of certifier	Red MD				9061			gned (Month,	4-4
drw 15			MD 110 Hospita	1 Road	,	e <b>21</b>	.2, Princ	e Fred	erick,	MD 206	78
State Registra		31. Date filed (Month, Day, Year)	32. Registra Sign		Span	K)					

DHMH 17 Rev 1/2001

			For State Registrar	State of Mar		ertificate of		Mental H	ygiene Reg. No.	211118	33984
ı	Physici	an	1. Decedent's Name (First, Middle, L	.ast)				2. Date of D	eath Day	y Year	3. Time of Death
d	/Medi		JOHN DANIEL H					OCT.	10	2008	3:00A M
	Examir	er	4a. Facility Name (If not institution, g				or Location of Dea	ath		County of Death	
			12861 TRAVILA  5. Social Security Number 6.		In yrs. last birthda	POTON /) If Under 1 Year		s. 8. Date of B		MONTGOM	
35	Funeral Director		470-50-3534 Usual Residence of Decedent	15 M 2□F 6		Months Days	Hours Mir	n. (Month, D MAR	av. Year)	47 9. Birth Cou	place (State or Foreign ntry) MN
	/land ow at		10a. State 10b. County	1	0c. City, Town or	ocation					10d. Inside City Limits
	death with the Maryland ms 23a or 28a-f show r must be notified at	ţō	MD MONTO	GOMERY	POTOM	AC					1 ☐ Yes 2 No
	th the or 28,	Director	10e. Street and Number			10f. Zip Code			10g. Citi	izen of What Cou	ntry?
	leath wi	ral	12861 TRAVILA			2085	54			USA	
Maryland 21215-0036	F 2 2	by Funeral I	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Year or Dates: 1	1969-	Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 No		Specify Yes or Nerto Rican, etc.)	0-	14. Race - Americ Black, White, Specify: WH	
2-0	72 hours "natural"; dical Exa	Completed	15. Decedent's I (Specify only highest g	Education	16a. Dec	edent's Usual Occu	pation	orking	16b. Ki	ind of Business/In	dustry
21	be filed within 72 h tal Hygiene. d other than "natu event, the Medical	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	I	e kind of work done DO NOT use retire		orking			
2	led w lygier her th		47 Fatheric News (First Maidalle Lea	5+	MED	IA CONSU					RELATIONS
anc	d be findal Findal Fied of	Be	17. Father's Name (First, Middle, Last DANIEL NORTON	•				ame <i>(First, Middl</i> N HARMS	,		
Z	2 should be filed and Mental Hygi is marked other aumatic event, t	ျှ	19a. Informant's Name/Relationship		19b. Mai	ling Address (Street	<u> </u>				2 Code)
	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		DEBRA BRENNAN	/ SPOUSE						C, MD 2	
Baltimore,	vages 1 a ent of Hea nt: If item y or othe	ĺ	20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3  4 ☐ Donation 5 ☐ Other (Spec	□Removal from State	20b. Place of Disp cemetery, cr		ice)	Date / 10/08	20c. Lo	ocation - City or To	own, State
Baltir	permit. Pages 1 and 2 s Department of Health at Important: If Item 27 is any injury or other trau	Ī	21. Signature of Funeral Service Lice	1177		22. Name and Addre HILTON P.O. BC	ess of Facility	L HOME			
			23a, Part1. Enter the disease, or col	mplications that caused the	e death. Do not e					E, MD	20838
4	Physician		23a. Part1. Enter the disease, or conshock, or heart failure. List onl Immediate Cause (Final			,,,,,,,,,,,,,,,,,,,,	ng, ceer as sargi	as of Toophatory	arroot,		Approximate Interval Between Onset and Death
á	/Medical		disease or condition resulting in death)	a. MELANON  Due to (or as a c							5 months
ě	Examiner		Sequentially list conditions,	h							
	D ti	iner	if any, leading to immediate cause. Enter Underlying	Due to (or as a c	onsequence of):						
	ecute and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a c	oncoguence of):		-				
68760,	ificate be executed g physician and as the burial-transit	edical E		d.	onsequence oi),						
	as a		IF FEMALE:								
Box	law requires that the death certif as been signed by the attending 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	23c. If yes, outcome pf   1 ☐ Live birth 2 [ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death 3	□Ectopic pregnanc □ Other (specify) _	у		2	23d. Date of delive Month	ery Day Year
P.0	at the	Phy	9 Unknown					-			
	res th	by	Part II. Other significant conditions	contributing to death but n	ot resulting in the	underlying cause giv	ven in Part I.	T .			he cause of death?
0.0	requi	sted					·		Yes 2L	□ No 3 □ Prot	pably 4 Unknown
or Vital Records,	ne law has b	Completed						24a. Was	psv	24b. Were auto prior to co	psy findings available mpletion of cause of
a	n: The ficate ha r, page							pen 1□ Yes	ormed? 2 No	death? 1 ☐ Yes	2 □ No
Ζ	Physician: this certificanal director,	Be	25. Was case referred to medical examiner? 1 ★ Yes 2 No	Hospital:		Oth	NO.51	eath (Check only			
0	Phy er this eral di	<u>۱</u>	27. Manner of Death	28a. Date of Injury	2 ER/Outpatie	III JUDON	4 Li Nursing	Home 5 Res 28d. Describe		Other (Specif	ý)
lon	Attending r death. ector: After	ig	1 Natural 5 ☐ Pending investigation	(Month, Day Ye	ear) Injury	Wor	rk? Yes 2 ∐ No	Esa. Bescribe	now injury	y occurred	
Division	l or Attendi after death. Director: A in by the fu	Certification:	3 Suicide 6 Could not to determined	De Place of injuny	- At home, farm, s Specify)			28f. Location City or To	Street and wn, State)	d Number or Rura )	al Route Number,
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2:	edical C	29a. Certifier (Check only one)	hysician: To the best of n iminer: On the basis of ex and mamer stated	amination and/or i	th occurred at the ti nvestigation, in my	me, date and plac opinion, death occ	e, and due to the curred at the time	cause(s) , date and	and manner as s I place, and due to	tated. o the cause(s)
	o the		29b. Signature and title of certifier ,	and manner stated		29c. Licens	se number		29d. Date	e signed (Month,	Dav, Year)
	- > - 0		· A K	remail		Un-	7655		,	0/08	
	(1), )	-	30. Name and address of person who	completed cause of deatl	n (Item 23a) (Tyne				1011	0100	
			BRUCE KRESSEL				WASHING	GTON, D	С		
7-	Sta		31. Date filed (Month, Day, Year)	32. Registrar's	Signature						
	Registr		0011	2000 Here	w J.	more					
DH	HMH 17 Rev 1/20	01				•					

		1 - State RegistrarAMEND#8, perF	H10/10/08,	of Marylar	•		t of He			R	eg. No.	2008	
Physici	an	1. Decedent's Name (First, Middle,							2	2. Date of Dea Month	th Day	Year	3. Time of Death
/Medic			. rene	arter						Octobe	1		9:15 p <sup>™</sup>
Examin	er	4a. Facility Name (If not institution,				•	Town, or Lo	cation of	Death			County of Death	
		Montgomery Gene  5. Social Security Number	ral Hosp.	7. Age (In yrs	last birthday)		Olney 1 Year   If	Under 2	4 Hrs.   8	3. Date of Birth		ntgomer	<u>-                                      </u>
Funeral Director		478-20-6545 Usual Residence of Decedent	1 □ M 2 🛣 F	83	Yrs.	Months		Hours	Min.	B. Date of Birth (Month, Day Jan. 24	Year)		nplace (State or Foreign untry) 7a
/land		10a. State 10b. County		10c. C	ity, Town or Lo	cation						T	10d. Inside City Limits
Mar.	ķ	Maryland N	ontgomer	у	Tak	oma P	ark						1 ☐ Yes 2 🔀 No
hours after death with the Maryland tural", or items 23a or 28a-f show of Evers in remust be multified at	Director	10e. Street and Number				10f. Zip	Code			1	0g. Citiz	en of What Cou	intry?
23a	<u>a</u>	7502 Carro			,		912					USA	
er dez	Funeral	11. Marital Status	Armed F		J.S. 13.	Was Deced fYes, spec	lent of Hispa cify Cuban, I	anic Origi Mexican,	in? (Spec Puerto Ri	ify Yes or No- ican, etc.)	14	<ol> <li>Race - Amer Black, White,</li> </ol>	
s afte	by F	1 ☐ Never Married 2 ☐ Marrie 3 🛣 Widowed 4 ☐ Divorced	d 1 □Yes If Yes, G Year or [	ive		I∐Yes 2	2 <b>∐X</b> No 5	Specify:			5	Specify: Whit	to
72 hours after death with the Marylan "natural", or items 23a or 28a-f show digal Evan har must be multhed at		15. Decedent's	Education				al Occupation				16b. Kind	d of Business/Ir	ndustry
hin 72 hc e. an "natui Modical	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (		(Give life. L	kind of wor DO NOT us	rk done duri se retired)	ing most o	of working	7			
e filed within 72 h al Hygiene. I other than "natu went, ir wordo	ĕ	12	Comogo (		Fi	nger	Print	Ana	lyst		FE	BI	
be file tal Hy ed othe event,	Be	17. Father's Name (First, Middle, La		_			18			First, Middle, I		Surname)	
snould be and Menta s marked umatic ev	၉	Robert Alexand	er Russe					Ev	a M.	Willia	ms		
2 e 8 E		19a. Informant's Name/Relationshi Richard E. Carte				~				Route Number Favern,	-	Town, State, Zi 23115	ip Code)
permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other tr once.		20a, Method of Disposition  1 ☐ Burial 2¾☐ Cremation 3  4 ☐ Donation 5 ☐ Other (Spe			Place of Dispo cemetery, creme tropol			torv	Oct.	. 9,		ation - City or T	
nit. P artme ortan Injur e.		21. Signature of Funeral Service Li			22	. Name an	d Address o	of Facility					Virginia
Imp any any	Ų.	Laus	0	00	F:	ranci 00 Un	s J.	Coll:	ins E Blvd.	Funeral	Hom	e Inc.	ng, MD 20901
Medical Examiner whysician and the burial-transit	ical Examiner	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Ener Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Cond Due to	(or as a consective) (or as a consectic Stem) (or as a consectic Stem) (or as a consectic stem)	Heart quence of): nosis		ıre						
ding Physician: The law requires that the death certificate After this certificate has been signed by the attending phys funeral director, page 2 should be detached for use as the I	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  □Yes 2 □No 9 □ Unknown	1 ☐ Live	tcome of pregn birth 2 Peta nant at time of nown	al death 3	Ectopic p					23	3d. Date of deliver Month	very Day Year
s that med be e deta	by P	Part II. Other significant condition	s contributing to d	eath but not res	sulting in the ur	nderlying ca	ause given i	n Part I.		23e. Did to	oacco us	e contribute to	the cause of death?
en siç										1 🗆 Ye	es 2 🖸	KNo 3 ☐ Pro	obably 4 ☐ Unknown
ate has be page 2 sho	Completed									24a. Was a autops perform	ned?	prior to co death?	topsy findings available ompletion of cause of
r this certific ral director,	Be	25. Was case referred to medical examiner?				_		6. Place o	of Death (	(Check only on			
his of	2	1 ☐ Yes 2★ No	Hospital:	Inpatient 2	ER/Outpatien				sing Home	e 5 ☐ Reside	ence 6	☐ Other (Spec	eify)
After t	ü	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date (Mor	of Injury hth, Day, Year)	28b. Time of Injury		8c. Injury at Work?		i	3d. Describe ho	w injury	occurred	
r death. <b>ector</b> : After by the fune	Certification:	2 Accident investiga 3 Suicide 6 Could no	t ha			M		2 □ N	-	V. 1			
oliter of Direct in by	ij	4 Homicide determin	ad Zoe, Flace	of Injury - At hing, etc. (Speci	iome, farm, stre ify)	et, factory	, office		28	St. Location (Si City or Town	reet and n, State)	Number or Rui	ral Route Number,
eral D		29a. Certifier	Physician: To the	a boot of my kn	owledge death	occurred	at the time	data and	I plana or	ad due to the s		and manner on	ototod
within 24 hours after death.  To the Funeral Director: A completely filled in by the funeral bit and the f	Medical		kaminer: On the b										
vithin To the	Me	29b. Signature and title of certifier				290	. License nu	umber		2	9d. Date	signed (Month	, Day, Year)
(0		> Stedagm	)				D378	30			Oct	ober 8	, 2008
10		30. Name and address of person w Johny Edappully		se of death (Iter			rt, #2	207,	Olne	y, MD 2	20832	2	
Sta Registra		31. Date filed (Month, Day, Year)	2008	egistrar's Signa	ature	cuts)							

DHMH 17 Rev 1/2001

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20	08	3	3	9	8	

		1- For State Registrar Certificate of D		Reg.	200 No.	0 3390
Physici Medical Exam		1. Decedent's Name (First, Middle,Last)  Andrew V. Clunie		2. Date of Death Month D October 16,	ay Year	3. Time of Death 0933 hrs
134			City, Town, or Location of Dea		4c. County of Death	0303 1113
			acoma Park		Montgomery	
Funeral Director	-		Under 1 Year If Under 24H Months Days Hours Mi		COL	nplace (State or Foreign intry) imaica
any		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
land f show	tor	Maryland Montgomery Silver				1 Yes 2 X No
15-0036 filed within 72 hours after death with the Maryland Hygene. 2d other than "natural", or items 23a or 28a-f sho t, the Medical Examiner must be notified at once.	Il Director	11414 Fairoak Drive	f. Zip Code 20902		Citizen of What Coun	-
leath wi	Funeral	1 Never Married 2 Married Armed Forces? If Yes,	ecedent of Hispanic Origin?(S specify Cuban, Mexican, Puerl		14. Race - Americ White, etc.	can Indian, Black,
after d		3 Widowed 4 Divorced If Yes, Give Year or Dates:	s 2 <b>X</b> No specify:		Specify: Bla	ıck
hours natur	ted t	during most (	Isual Occupation (Give kind of working life. DO NOT use re		6b. Kind of Business/Ir	ndustry
1215-0036 d be filed within 72 hours after fettal Hygiene. rarked other than "matural", event, the Medical Examíner	Completed by	Elementary/Secondary (0-12)  College (1-4 or 5+)  Sale:	s Representati	ve	Automotive	
21215-0036 und be filed within 7 Mental Hygiene. marked other than e event, the Medica		17. Father's Name (First, Middle, Last)	18.Mother's Nam	ne (First, Middle, Mai	iden Surname)	
12 Deenta	To Be	Reginald Adulphus Clunie  19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Ad	dress (Street and Number or	Adassah		Zin Onda)
MD 2 d 2 shou lith and 1 n 27 is numatic			Fairoak Drive			
ore, less and selection of Healt littern less trans		20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from State 20b. Place of Disposition crematory or other process.	place)	Date Oct. 25	20c. Location - City or	Γown, State
Baltimore, permit. Pages I as Department of He Important: If ite		4 Donation 5 Other Specify: Parklawn Me	emorial Park	2008	Rockville	,Maryland
Baltimore, MD 2's permit. Pages I and 2 should Department of Health and MI Important: If item 27 is minjury or other traumatic e		All. w/ / ./ Frai	e and Address of Facility ncis J. Collin University Bl	s Funeral	Home Inc.	g, MD 20901
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the medialure. List only one cause on each line.	ode of dying, such as cardiac	or respiratory arrest	, shock, or heart	Approximate Interval Between Onset and
xaminer		Immediate Cause (Final disease or condition resulting in death)  a. Biventricular cardiac  Due to (or as a consequence of):	dilatation and	d hypertr	ophy	Death
		Sequentially list conditions, b.				
	ine	if any, leading to immediate cause. Enter Underlying Cause				
ited d ansit	Examiner	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):				
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical	X UNPENDED AMENDED 23a,27,permE, g8	85 11/21/08 T	Γ		
3760, ficate be g physic s the buri		IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery	
Box 687 he death certific the attending 1	iciar	past 12 months?  4 Pregnant at time of death 5 Other	eath 3 Ectopic pregr (Specify)	nancy	Month D	ay Year
BOX the death cy the attenty the detents	Physician	1 Yes 2 No 9 Unknown 9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the unde	Death	Loop Did tobo		
ires that the signed by the detached	۵	rath. Other significant conditions continuing to death but not resulting in the under	nying cause given in Part I.		cco use contribute to t	
ords, v require s been s should t	ompleted			24a. Was an		opsy findings available
Division of Vital Records, tal or Attending Physician: The law requir is after death.  al Director: After this certificate has been seled in by the funeral director, page 2 should I	dmo			autopsy performe 1 ✓ Yes 2	ed? death?	ompletion of cause of
Vital R ysician: T his certific director, p	BeC	25. Was case referred to medical examiner?	26.Place of Death (Check			
f Vid Physic er this	P	1 V Yes 2 No Inpatient 2 V ER/Outpatient 3			esidence 6 Other:	
on of anding Phith. T: After to the funeral	ü	27. Manner of Death  1 X Natural 5 Pending  28a. Date of Injury (Month, Day, Year)  28b. Time of Injury	28c. Injury at Work?	28d. Describe how	v injury occurred	
Division pital or Attencours after death reral Director:	ertification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, fa	ctory, office building, etc.		eet and Number or Rur	al Route Number, City
Di spital o nours al neral I filled	Οŀ	4 Homicide determined (Specify)		or Town, Stat	e)	
Divis  To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred one)  Wedical Examiner: On the basis of examination and/or investigation,				
	Med	and manner stated.  29b. Signature and title of certifier	29c. License number		9d. Date signed (Mon	
3 PM	"	( anderbell	O.C.M.E.		October 17, 2008	
	ŀ	30. Name and address of person who completed cause of death (Item 23a)				
	2012		reet, Baltimore, MD 21:	201		
Regis	ate rar	31. Date filed (Month, Day, Year) Registrar's Signature				

ORIGINAL

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 7:00 P.M Month Day Vea **Physician** October 200 Ethel Corrine CARBAUGH 10 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington County Hospital Hagerstown Washington Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Hours Min. Date of Birth (Month, Day, Year) **Funeral** Months Days 1 □ M 2 👽 F 214-09-5071 93 Director April 14 1915 Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County ral", or items 23a or 28a-f show 1 ☐ Yes 2 ☑ No Director Maryland Washington Maugansville 10g. Citizen of What Country? 10e. Street and Number 10f Zip Code death with 13838 Village Mill Drive 21767 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after one of Health and Mental Hygiene. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 2X No 3altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: 2 3 Widowed 4 □ Divorced White "natural" Completed d other than "natur event, the wedical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) T traumatic event Elementary/Secondary (0-12) College (1-4or 5+) 12 0 Homemaker Her own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) æ Thomas J. Ruth ပ Lillian Jackson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health a Ellen Schindler - Daughter 1349 Grade Road, Falling Waters, W. Va. 25419 item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it any Injury or conce. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Broadfording Cemetery 10/15/08 Hagerstown, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Minnich Funeral Home I. Vesta red 415 E. Wilson Blvd. Hagerstown, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) cate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 2 No 3 Probably 4 Unknown 1 ☐ Yes Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 DNo certificate 1 Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 1 ☐ Yes 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After 1 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 24 hours a Hospital Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only and manner stated. within 2

1-HC

State Registrar

31. Date filed (Mor 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

mo

29b. Signature and title of certifier



29d. Date signed (Month, Day, Year)

Hageistanmo

			For State Registrar	State of I	Marylan		artment of I			lental		ene g. No.	2008	33	988
	<i>\$</i>		Decedent's Name (First, Middle,	Last)						2. Date	of Death			3. Time	of Death
	Physici /Medic		Anna Margaret	Cook						Octo	ber	9 <sup>Day</sup> :	2008 <sup>Year</sup>	8:0	мА ОС
-	Examin		4a. Facility Name (If not institution,	•			4b. City, Town,	or Location	of Death				ounty of Deatl	_	
- "			Shanti Home Ass:			last histhday)	Laurel If Under 1 Year	T If Under	r 24 Hrs	0 Data		Pri	nce Geo		au Fausies
	Funeral Director		5. Social Security Number 6 280-03-6267	. Sex 1 □ M 2 □ XF 7.	Age (In yrs. I. 93	Yrs.	Months Days		Min.	8. Date (Mont	th, Day,	<sup>year)</sup> 915	Ohic	hplace (State untry)	e o <i>r r-oreig</i> n
			Usual Residence of Decedent		75					Jan .	<i>J</i> , <u>1</u>		OTIEC		
	rylan	_	10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside	
	Ba-f s	cto		George's	Laur	rel									s 2 No
	vith th	Ë	10e. Street and Number	D			10f. Zip Code					_	en of What Co	untry?	
	sath v	eral	6406 01d Sandy S	opring Koa 12. Was Decede		6 112 1	20707	Hienanio Or	rigin? (Sn	noify Voc		SA	1. Race - Ame	rican Indian	
10	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show digal Examination to rutified at	<b>Funeral Director</b>	<ul><li>11. Marital Status</li><li>1 ☐ Never Married 2 ☐ Married</li></ul>	Armed Force	<u>s?</u>	ł	Was Decedent of If Yes, specify Cub			Rican, etc	2.)		Black, White	e, etc.	
036	urs a	δ	3 Widowed 4 □ Divorced	If Yes, Give Year or Date			1 □Yes 2 X No	Specify	<i>'</i> :			8	Specify: Whi	Lte	
5-0	72 ho natur	Completed	15. Decedent's (Specify only highest)	Education grade completed)		16a. Dece	dent's Usual Occu kind of work done DO NOT use retire	pation	st of worki	na	1		of Business/I		
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9	Hygie Hygie ther i	ပ္သ	12 17. Father's Name (First, Middle, La	ist)		UIIIC	e Mariagei		er's Name	e (First. M		hur aiden S			
Maryland 21215-0036	ld be lental ked o	To Be	John Edward Thor					Beati					,		
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	and 2 salth n 27 ii		Cecil H Cook, I	II/son		11812	2 Bristo	lwood	Terr	ace 1	Laur	el,	MD 207	708	
ore	Jes 1 I of H		20a. Method of Disposition 1 ☐ Burial 2 [XCremation 3	□ Removal from Sta	nte Ce	emetery, cřen	sition (Name of natory or other pla	· ·		Date	1		ation - City or 1		
Baltimore,	t. Pag tmen tant: tant:		4 ☐ Donation 5 ☐ Other (Spe	cify)	Che		ke Cremat						sville,	_	
Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy lijury or other traumatic event, I'm Madical Evariting 1. ust be rutified at once.		21. Signature of Funeral Service Lic	Leilte	MO1	L251 B	Name and Addr Ding Home Everly L	ess of Facili e Crer Heck	natio Krott	n Se	rxic	cla	P.O. Bo rksvill	æ,7₩	21029
			23a. Part 1. Enter the disease, or co shock, or heart failure. List or	omplications that causely one cause on eacl	sed the death h line.	n. Do not ent	er the mode of dy	ing, such as	s cardiac o	or respirat	ory arres	st,		Approxima Interval B	etween
	Physician		Immediate Cause (Final disease or condition	- Coronar	v Arte	ery Die	sease							Onset and	
Ų	/Medical Examiner		resulting in death)	Due to (or	as a consequ	uence of):	or many								
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	uted I Insit	Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	Due to (or	as a consequ	ichico ory.									
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Вох	eath certific attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?		me of pregna h 2□ Fetal nt at time of d	death 3	Ectopic pregnan Other (specify)	су				23	d. Date of deli Month	ivery Day	Year
O.	uires that the de signed by the a d be detached t	ysic	1 □ Yes 2 ☑ No 9 □ Unknown	9 Unknow		eath 5L	□ Other ( <i>specity</i> ) <sub>□</sub>								
۹,	that ned b deta		Part II. Other significant condition	s contributing to deat	h but not resu	ulting in the u	nderlying cause gi	ven in Part	l.	23e.	Did toba	acco us	e contribute to	the cause of	f death?
rds	quire; en sig uld be	q pa	Congestive Hear	t Failure							1 ☐ Yes	2 🗆	No 3☐ Pr	obably 4	Unknown
0၁	aw requir as been s 2 should	plet	Cardiac Arrhyth	mia							Was an		24b. Were au	topsy finding	s available
Vital Records,	Attending Physician; The law ar deeth. rector: After this certificate has by the funeral director, page 2 s	Completed by								10	autopsy perform /es 2	ed? X No	death?	completion of 2  No	cause of
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of	Physi this o	P.	1 ☐ Yes 2 No		atient 2		" O DOY I						Other (Spec	cify) Liv.	isted ing
uo	ding h. After funer	tion	27. Manner of Death  1 X Natural 5 ☐ Pending 2 ☐ Accident investigat	28a. Date of (Month,	Day, Year)	28b. Time of Injury	Wo	ıryat ⊮rk? ∃Yes 2.⊑		28d. Desc	ribe hov	v injury	occurred		
Division of	or Attendation of the street of the street or	fica	3 Suicide 6 Could no	the -	Injury - At ho	me, farm, str	eet, factory, office			28f. Locat	ion (Stre	et and	Number or Ru	ıral Route Nu	ımber.
言	al or safter	Certification: To	4 ☐ Homicide determine	building,	, etc. (Specify	()					or Town,				
	To the Hospital or Attending Physician: The law requires that the death certifin the hours affected that The Thin is certificate has been signed by the attending is To the Funeral Director. After this certificate has been signed by the attending is completely filled in by the funeral director, page 2 should be detached for use as	Medical C	29a. Certifier 1 Certifying (Check only one)	Physician: To the be caminer: On the basi and manner	is of examinat	wledge, deatl tion and/or in	h occurred at the vestigation, in my	time, date a opinion, de	and place, eath occur	and due t red at the	o the ca time, da	use(s) a te and p	and manner as place, and due	s stated. to the cause	e(s)
	To the within To the	Me	29b. Signature and title of certifier	Pa.			29c. Licen	se number			29	d. Date	signed (Month	h, Day, Year)	
			> HF	mora	pnu	>	D2318	81			00	tob	er 9, 2	2008	
	200		30. Name and address of person wh				Print)								
_ \	3/4		R.G. Bhojraj, M				. Suite	10 Bla	adens	burg	, MD	20	710		
	Sta Registr		31. Date filed (Month, Day, Year)  OCT 10		istrar's Signat		house								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For AMEND#23 Per PHYState of Maryland / Department of Health and Mental Hygiene State Registrar 10/08/2008 AACO HEALTH DEPT. CMH Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day October 6,2008 Physician 12:45 AM Dalv .TR. Edward Α. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Anne Arundel Crownsville 707 Herald Harbor Road If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 02/02/1944) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours 1 X M 2 □ F Yrs Washington DC 64 Director 579-54-5666 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County ns 23a or 28a-f show must be notified at 1 ☐ Yes 2 ☐ No Crownsville MD Anne Arundel Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number death with 707 Herald Harbor Road 21032 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Was Decedent Ever in U.S Armed Forces? "natural", or items Black, White, etc. and 2 should be filed within 72 hours after of eath and Mental Hygiene. amed Folces: 1 MYes 2□No If Yes, Give Vietnam Year or Dates: 1 Never Married 2 Married Specify: White Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed by 3 Widowed 4 □ Divorced other than "natur 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Washington DC 02 Police Officer 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charland is marked Daly Daly SR. Rita Edward Α. ို 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 705 McCrone Drive Crownsville, MD 21032 Peter Daly Son 27 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Important: If its any Injury or o once, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 10/06/08 Glen Burnie, MD Atlantic Crematory 4 Donation 5 Dother (Specify) 21. Signature of Fundral Service Licenses Hardesty Funeral Home P.A. 851 Annapolis Road Gambrills, MD 21054 Valu 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Fnd Stage Liver Disease Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner 10H) a sequentially in conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence or) Examine The law requires that the death certificate be executed and that initiated ever resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 2 No 9 Tilnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DI De Curo 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 □ No 1 ☐ Yes or Attending Physician; Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury I Director: After the 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

OHIGH

31. Date filed (Month, Day, Year) OCT 0 8 2008

29b. Signature and title

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) gistrar's Signature

Registrar

29c. License number

29d. Date signed (Month, Day, Year)

08-07736 Ramatu Dainkeh Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2002

imato Danken		- For State Certificate	of Death		Reg	No	
Physicia	n/ 1	Decedent's Name (First, Middle,Last)			2. Date of Death Month October 14,	Day Year	3. Time of Death 0646 hrs
edical Examin		RAMATU DAINKEH  4a. Facility Name (if not institution, give street and number)		r Location of Dea		4c. County of Deat	1
		Doctors Community Hospital	Lanham ) If Under 1 Ye	ar If.Under 24H	rs: 8 Date of Birth	Prince Georg	rthplace (State or Foreign
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 151-02-1731 1_M 2 F 31	Yrs. Months Da		_	l Co	ERRA LEONE
any	-	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Lo	ocation				10d. Inside City Limits
<u> </u>		MD PRINCE GEORGE'S LANHAM					1 X Yes 2 No
farylar 1888-f s	Director	10e. Street and Number	10f. Zip Code		109	g. Citizen of What Cou	untry?
3a or		9963 GOOD LUCK ROAD APT T-3	20706	0.1-1-0.1	Carify Van as Na	SIERRA LEG	ONE rican Indian, Black,
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she traumatte event, the Medical Examiner must be notified at once	Funeral	1 Never Married 2 X Married Armed Forces?	Was Decedent of H If Yes, specify Cuba	an, Mexican, Puer	to Rican, etc.)	White, etc.	Tical Indian, Sidok,
after	Ď.	3 Widowed 4 Divorced If Yes, Give Year 1	Yes 2 X N		f work done	Specify: B]  16b. Kind of Business	LACK
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5-0036 led within 72 Hygiene. other than	Completed		RSE			PRIVATE	
5-00 iled with Hygien I other		17. Father's Name (First, Middle, Last)		l .	me (First, Middle, M		
21215-0036 and be filed within 7 Mental Hygiene. marked other than	B	IBRAHIM DAINKEH  19a. Informant's Name/Relationship (Type, Print )  19b. M	ailing Address (Str		KAY CONTE	ber, City or Town, Sta	te, Zip Code)
Baltimore, MD 21215-C pernit. Pages I and 2 should be filed v Department of Health and Mental Hygi Imporgant: If item 27 is marked oth injury of other traumatic event, the I			912 RIVER	CHASE C		E, MARYLANI	
G, N 1 and 1 Health Fitem	İ	crematory	sposition (Name of or other place)	cemetery,	Date	20c. Location - City of	or Town, State
more Pages 1 nent of H annt: If i	+	4 Donation 5 Other Specify: MD NAT:	IONAL CEM		0-17-08	LAUREL, MA	
Baltimore, permit. Pages 1 a Department of He Imporant: If ite		21. Signature of Fundal Service Licensee				INS FUNERA ER, MARYLAN	
Physician		20a. Part I. Enter the disease, or complications that caused the death. Do not en					Approximate Interval Between Onset and
Medical	۱	failure. List only one cause on each line.  Immediate Cause (Final disease a. <u>Acute subarachnoi</u> e					Death
∤aminer		or condition resulting in death)  Due to (or as a consequence of):					
	<u>.</u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	eurysm				
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760, icate b			Fatal doath	3 Ectopic pre	gnancy	23d. Date of deliv Month	ery Day Year
Box 687  e death certific  the attending ped for use as the	cian	past 12 months?    Live birth   2	Fetal death Other (Specify)				•
BOy e death the att	Physician/	1 Yes 2 No 9 V Unknown 9 Unknown  Part II. Other significant conditions contributing to death but not resulting in	the underlying cause	e given in Part I	23e. Did to	bacco use contribute	to the cause of death?
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ords, I	Completed by	hypertensive earare acceptance			24a. Was		autopsy findings available to completion of cause of
COF e law re e has b	mple					rmed? death	?
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Vita nysicia this cer	To Be	examiner? Hospital: 4 Inneficet 2 of EP/Outp					her:
n of V	n: T	27. Manner of Death  1 Natural 5 Pending  28a. Date of Injury (Month, Day, Year)  28b. Tin		Injury at Work? Yes 2 No		how injury occurred	
Sior Attend death ector:	catic	2 Accident See. Place of Injury - At home, farm				Street and Number or	Rural Route Number, City
Division of Vital Records, tal or stending Physician: The law require irs after death.  **Al Director: After this certificate has been sited in by the funeral director, page 2 should be the funeral director, page 2 should	Certification:	3 Suicide 6 Could not be determined (Specify)	,,		or Town, S		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi			occurred at the time	e, date and place, nion, death occurr	and due to the caused at the time, date	se(s) and manner as s and place, and due t	stated. o the cause(s)
Tot with Tot	Medical	and manner stated.  29b. Signature and title of certifier		cense number	<del></del>	29d. Date signed (	
(D 4)		111 ans un	0	.C.M.E.		October 15, 2	008
De.		30. Name and address of person who completed cause of death (Item 23a)	444 D C'	at Dolliman	MD 24204		
		Russell Alexander MD. Assistant Medical Examiner  31 Date filed (Month, Day, Year) 32. Registrar's Signature	111 Penn Stre	et, palumore	, IVID 2 120 1	OCME	
S Regis	tate	00=0 1 2000	,			OCME	

**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 7, 2008 3:15 P M October 0 Mildred Jarvis Feeley /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel 8. Date of Birth (Month, Day, Year) 3/17/1919 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Funera! 1 □ M 2 🕅 F Months Days Hours 89 Massachusetts Director 040-22-2694 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County show 7 Is marked other than "natural", or items 23a or 28a-f shot traumatic event, the Modest Exp. in or must be to differ at 1 □Yes 2 No Director Maryland| Anne Arundel Annapolis death with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 701 Bay Front Dr. 21403 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 □Yes 2 XI If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 □Yes 2X No Specify: Specify: à 3 ☑ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than any injury or other traumatic event, It a IM once. Elementary/Secondary (0-12) College (1-4or 5+) Elementary School Teacher vears 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Be Walter Arthur Jarvis Elwilda Young ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3301 San Domingo St., Clearwater, FL 33759 Jeffrey E. Feeley/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State St. Mary's Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 10-11-08 Needham, Massachusetts 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signatura Funeral Service 2973 Solomons Island Rd., Edgewater, MD 21037 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final on Physician disease or condition resulting in death) /Medical as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Day to for as a gorsyculence of: law requires that the death certificate be executed Examin and burial-trar Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached fo P.0. 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ₽. cate has been signated by page 2 should b 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an certificate 1 ☐ Yes 2 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and titl 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Defense thuy 1-10 Registrar's Signature 31. Date filed (Month, Day, State OCT 0 8 2008 Registrar

			1 - For State Registrar	State of M			of Health and of Death	Mental Hy	giene Reg. No.	08	33992
	Physici		1. Decedent's Name (First, Middle, Elsie Belle F					2. Date of Domestin	Day	2008	3. Time of Death 11: 20a M
	/Medi Examir		4a. Facility Name (If not institution,	give street and number)		4b. City, To	wn, or Location of Deat			ity of Death	
	Funeral Director		3515 Hall Cro 5. Social Security Number 214-58-1507  Usual Residence of Decedent		ge (In yrs. last birthda) 87 Yrs.		Owings Year If Under 24 Hrs. Pays Hours Min.	8. Date of Bi (Month, D. 4/20/	ay, Year)	Coun	lace (State or Foreign
	Maryland f show led at	tor	10a. State 10b. County	lvert	10c. City, Town or L	ocation.	Owings	8 4 50 V 100		10	0d. Inside City Limits
	with the ta or 28a	I Direc	10e. Street and Number 3515 Hall Cre		1	10f. Zip Co			10g. Citizen o		try?
920	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent Armed Forces?		. Was Deceden If Yes, specify	t of Hispanic Origin? (S Cuban, Mexican, Puer	pecify Yes or Note to Rican, etc.)	o- 14. R	JSA ace - America ack, White, e	
21215-0036	filed within 72 ho Hygiene. rther than "natur ent, the Medical I	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-4or	(Giv		lone during most of wor etired)	rking		Business/Ind	lustry
and 2	should be filed withir and Mental Hygiene. marked other than imatic event, the Me	Be	12 17. Father's Name (First, Middle, Li Harry Lee Par	•		Homem	18. Mother's Nar	, .	e, Maiden Surna	Home	
Maryland	id 2 should th and Men 77 is marker traumatic	으	19a. Informant's Name/Relationship George Fellow	(Type. Print)			treet and Number or Ru  Creek La		er, City or Tow		
Baltimore,	0 0		20a. Method of Disposition  1   ↑ Burial 2 □ Cremation 3  4 □ Donation 5 □ Other (Spe	B □ Removal from State	20b. Place of Disp cemetery, cri	osition (Name o ematory or othe	of r place)	Date	20c. Location	- City or To	wn, State
Baltin	permit, Page Department of Important: If any injury of once.		21. Signature of Funeral Service Li		4	22. Name and A	Gdns. 10/ Address of Facility R 430, Dun	aymond	-Wood	<u>rk, N</u> F.H., 1754	1D , P.A.
	Physician /Medical Examiner		23a. Part1. Enter the disease, or c shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	a.	d the death. Do not er					(	Approximate Interval Between Onset and Death
8760,		al Examiner	Sequentially list conditions, if any, leading to immediate English of the Cause (Disease or injury that initiated events resulting in death) Last	с	a consequence of):						
O. Box 687	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 moons? 1 □ Yes 2 ☑ No 9 □ Unknown	d	2 Fetal death 3	□Ectopic pregr □ Other (specii				Pate of deliver	ry Day Year
ords, P.	w requires that the bound by should be detained by	ρ	Part II. Other significant condition	s contributing to death b	_	underlying caus	e given in Part I.				e cause of death? abiy 4 Minknown
or Vital Records,	The larate has	Completed						24a. Was auto perfo 1□ Yes	psy ormed?	prior to con death?	osy findings available npletion of cause of 2 100
/it	cian ertifi ector	Be	25. Was case referred to medical examiner?				26. Place of Dea	th (Check only	one)		
7	S 0 =	2	1 ☐ Yes 2 ☐ N/6	Hospital: 1 ☐ Inpatie	ent 2 ER/Outpatie			lome 5 Resi	idence 6 □O	ther (Specify	)
sion o	ng fter nei		27. Manner of Death  1			of 28c.	Injury at Work? 1 ☐ Yes 2 ☐ No		how injury occu		
Division		Certification:	3 Suicide 6 Could no determine	ad   Zoe. Flace of Inj	ury - At home, farm, si c. <i>(Specify)</i>	treet, factory, of	fice	28f. Location ( City or To	Street and Nun wn, State)	nber or Rural	Route Number,
	o the Hospital or thin 24 hours afte the Funeral Dil mpletely filled in	Medical (	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the best aminer: On the basis o and manner st	f examination and/or i	th occurred at t	he time, date and place my opinion, death occu	e, and due to the arred at the time	cause(s) and r date and place	nanner as sta e, and due to	ated. the cause(s)
	omp	M	29b. Signature and title of certifier			29c. Li	cense number		29d. Date sign	ed (Month, L	Day, Year)

Division or Vital Records, P.O. Box 68760,

State Registrar

29d. Date signed (Month, Day, Year)

address of person who completed cause of death (Item 23a) (Type, Print) 30. Name an

31. Date filed (Month, Day, Year)

32. Registra Signature 2008

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

Physicia /Medica Examine

Funeral Director

For State	State of	Maryland / D	epartme <i>Certifica</i>						/ 11111	3399
Registrar  1. Decedent's Name (First, Middle, Robert.	Last) Davis	Gravell	Cortino	210 01 1	Jean		2. Date of Dear			3. Time of Death 1 4 1 2
a. Facility Name (If not institution, Holy Cross				ty, Town, or 1ver				4c.	County of Dea Contgo	mery
169-18-1414	6. Sex 7 1 ⊠ M 2 □ F	. Age (In yrs. last bir)	hday) If Und Month	der 1 Year Is Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day 8 / 08 /	Year) 192	0 9. Bi	rthplace (State or Fore country) PA •
Day   December   Dec	omery	10c. City, Town	or Location or Sp	ring						10d. Inside City Lim 1 ☐ Yes 2 🛣
0e. Street and Number 12205 Bushey	Drive		10f. 2	Zip Code 209	02		1	0g. Cit	izen of What C USA	ountry?
Marital Status     Never Married 2 X Marrie     Widowed 4 □ Divorced	12. Was Decedd Armed Force 1 Tyres 2 If Yes, Give Year or Date	es?		cedent of Hoecify Cuba	ispanic Oi in, Mexica Specify		ecify Yes or No- Rican, etc.)		14. Race - Am Black, Whi Specify:	
15. Decedent' (Specify only highest Elementary/Secondary (0-12)	s Education t grade completed)  College (1-4		Decedent's U (Give kind of v life. DO NOT Securi	work done o use retired	during mos f)	st of worki	ng		nd of Business	
17. Father's Name (First, Middle, L Davis Grave	'				18. Moth	er's Name	(First, Middle, I n McCo	Maiden CM 1	Surname) C	
19a. Informant's Name/Relationsh Robert B. Grav		19b.	Mailing Addre	ss (Street a	and Numb	er or Rura Live	Silve	r, City o	pring,	.7¶&° <sup>de</sup> 20902
20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 4 ☐ Donation 5 ☐ Other (Sp		cemeter cemeter	Disposition (A y, crematory o	r other plac			) / 2008		eltsvi	r Town, State 11e <b>,</b> Md
21. Signature of Funeral Service L			23-Name	and Addres	ss of Facili	ALDI a Bl	FUNER	AL vei	SERVI Spri	CE,P.A. ng,Md209
23a. Part 1. Enter the disease, or o shock, or heart failure. List o Immediate Cause (Final			not enter the m	ode of dyin						Approximate Interval Between Onset and Death
disease or condition resulting in death)	Due to (or	ardial i ras a consequence c nary art	of):		se					years
Sequentially list conditions, fany, leading to immediate cause. Enter Underlying Cause (Disease or injury	b Due to (or	as a consequence of	of):							
that initiated events 1	CDue to (or	as a consequence of	of):							
IF FEMALE: 23b. Was decedent pregnant In the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live bir	ome of pregnancy th 2□ Fetal death nt at time of death vn	3 ☐ Ectopi 5 ☐ Other		<i>y</i>				23d. Date of de Month	elivery Day Year
Part II. Other significant condition	ns contributing to dea	th but not resulting in	the underlying	g cause give	en in Part	i.				to the cause of death Probably 4 <b>本</b> Unkno
							24a. Was a autops perfori 1 □ Yes	y	24b. Were a prior to death?	autopsy findings availa completion of cause s 2 □No
25. Was case referred to medical examiner?	Hac-ta-ti			T		e of Death	(Check only on	e)		
1 ☐ Yes 2 🔀 No  27. Manner of Death 1 🖾 Natural 5 ☐ Pending	28a. Date of	oatient 2 ER/Ou Injury 28b. T Day, Year) Ir	ime of njury	DOA Othe	4 ⊔ N y at		me 5 ☐ Reside 28d. Describe ho			ecify)
2 Accident investigations of Could not determine	ot be 28e. Place of	f Injury - At home, far , etc. <i>(Specify)</i>	m, street, fact		Yes 2□		28f. Location (Si City or Town			Rural Route Number,
29a. Certifier 1 X Certifying (Check only one) 2 Medical E	Physician: To the becaminer: On the bas	is of examination and	, death occurr d/or investigati	ed at the tir	ne, date a pinion, de	nd place, ath occurr	and due to the c	ause(s	) and manner a d place, and du	as stated. ue to the cause(s)
29b. Signat and title of certifier	and maille	. c.a.ou.		9c. License						ith, Day, Year)

10

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) **OCT 1** 0 2008

Registrar DHMH 17 Rev 1/2001

State

30 Name and address of person who completed cause of death (Item 23a) (Type, Print) Suresh K.Gupta M.D. 9801 Georgi 9801 Georgia Ave. Silver Spring, Md 20902 32 Registrar's Signature

D32332

29d. Date signed (Month, Day, Year)
Oct. 9, 2008

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2008 1:30 Рм Havener October Betty Jane /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3403 South Leisure World Blvd Montgomery Silver Spring If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Dec. 19,1929 Social Security Numbe 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 □ M 2 🗓 F 212-24-4132 78 Director Maryland Usual Residence of Decedent the Maryland 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show items 23a or 28a-f shov Silver Spring Director Montgomery 1 ☐ Yes 2 No 10e Street and Number 10f. Zip Code 10g Citizen of What Country? death with 3403 South Leisure World Blvd 20906 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 M No IfYes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Examiner r Black. White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ٥, 1 □Yes 2X No Specify: White Specify: <u>ک</u> ir than "natural", o 3 ♥ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; if Item 27 is marked oth any injury or other traumatic event once. Be Frank Schneider Lillian Blundon ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 34134 Judy Wharen/ Daughter 23349 Old Meadowbrook Circle, Bonita Springs, 20b. Place of Disposition (Name of Metropolitan Crematory or other place)

Crematory Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Buriaì 2 【Cremation 3 ☐ Removal from State October 9,2008 4 □ Donation 5 □ Other (Specify) Alexandria, Virginia 21. Signature of Funeral Service Licens 22. Name and Address of Facility
DeVol Funeral Home, 10
Gaithersburg, 10 East Deer Park Drive, MD 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Non Small Cell Cancer 7 Months disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) physician sthe burial P.O. Box 68760, Physician/Medical attending p for use as t 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an s certificate has be irector, page 2 s 1 □Yes 2 No director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 X Natural 5 ☐ Pending investigation ours after death.

neral Director; Ai
filled in by the fu 1 ☐Yes 2 ☐ No 2 Accident 6 ☐Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical To the Hosp within 24 ho To the Fune completely f (Check only one and manner stated 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D0061083 October 9, 2008 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul Thambi, M.D., 9707 Medical Center Drive Suite 300, Rockville, MD 20850 31. Date filed (Month, Day, Year) . Registrar's Signature State 09 2008 Registrar

Certificate of Death

2. Date of Death

3. Time of Death

1. Decedent's Name (First, Middle, Last)

October 9 2008 ar **Physician** 1:30 A M Stewart Coale Harris /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Mount Airy Frederick Kline Hospice House If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Oct 24, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖾 F Mary Land 96 **Director** 215-12-7866 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Funeral Director MD Frederick Adamstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 2780 Washington Street 21710 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 🔣 No Specify: Specify: White ģ 3X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7:
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ne any Injury or other traumatic event, I'm Madia once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Domestic Worker Private Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Webster Coale Mary Elizabeth Eckers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4105 Elizabeth Drive MT. Juliet, TN 37122 19a. Informant's Name/Relationship (Type. Print) Shari Kraemer/POA 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Chesapeake Crematory 10/10/08 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 23a. Part 1. Enter the the ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Stroke **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 - Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy 2 📈 No 1 ☐ Yes 1 ☐ Yes 2 🗆 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) hospice 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1X Natural 1 ☐ Yes 2 🗆 No 2 Accident 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Umbedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) October 9, 2008 heli ft D61611 MYS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sheli Agarwal, M.D. 300 South Church Street Middletown, MD 21769 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 1 0 2008 Registrar

DHMH 17 Rev 1/2001

			Type or Print in B State of Maryland				•	•			
		For State Registrar	otato or maryian		rtificate of D		Reg.	0000	3 33006		
Physici /Medic		1. Decedent's Name (First, Middle, Las EDWARD M.	•				_	Day Year	3. Time of Death		
Examir		4a. Facility Name (If not institution, give	4b. City, Town, or Location of Death  Cambridg:,			4c. County of Death Dorchester					
Funeral Director		213-14-3149	7. Age (In yrs. I. 3. M 2 F 91	as <i>t birthday)</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye 5 / 2 9 / 1 9 ]	ar) C	thplace (State or Foreign ountry) aryland		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other fraumatic event, the Medical Examiner must be notified at once.	To Be Completed by Funeral Director	Usual Residence of Decedent  10a. State									
Physician /Medical Examiner	ical Examiner	21. Signature of Funeral Service Licensee  22. Name and Address of Facility Framptom Funeral Home, PA 216 N. Main St. Federalsburg, MD 216 32  23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  22. Name and Address of Facility Framptom Funeral Home, PA 216 N. Main St. Federalsburg, MD 216 32  Approximate Interval Between Onset and Death  Onset and Death  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):									
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours alter death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	ted by Physician/Medical	Part II. Other significant continuous continuous to death but not resulting in the underlying cause given in Part II.						23d. Date of delivery  Month Day Year  23e. Did tobacco use contribute to the cause of death?  1			
sician; The law certificate has b rector, page 2 sh	Be Completed	25. Was case referred to medical examiner?	Hospital:		24a. Was an autopsy performed?  1 Yes 2 No 1 Yes 2 No 26. Place of Death (Check only one)						
ital or Attending Pny rs after death. ral Director: After this led in by the funeral di	Certification: To	12 Inpatient 2 Envotipation 3 DOA 4 Nursing Home 5 Hesidence 6							ural Route Number,		
To the Hosp within 24 hou To the Funer completely fill	Medical	29a. Certifier (Check only one)  29b. Signature and title of certifier	rsician: To the best of my know iner: On the basis of examinat and manner stated.	vledge, death ion and/or in	vestigation, in my op	number	red at the time, date	and place, and du  Date signed (Mon	e to the cause(s) th, Day, Year)		
		30. Name and address of person who on NOMAN TIMNU		23a) (Type,	Print)	7924 AUKR 100	(E M	0 2/6/2			

State Registrar 31. Date filed (Month, Day,

OCT 1 7 32. Registrar's Signature

21613

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Death Month Day Year October 8, Shirley B. Katz 2008 10:50 PM 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 1 ☐ M 2 🛣 F 577-36-4462 78 Sept. 15, 1930 Washington, Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 □ No Montgomery Wheaton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13306 Galvez Street 20906 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 21 No Specify Specify: White 3 ₩ Widowed 4 Divorced

16a. Decedent's Usual Occupation

Book Keeper

20b. Place of Disposition (Name of cemetery, crematory or other place)

(Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

Private Industry

20c. Location - City or Town, State

Approximate Interval Between Onset and Death

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No

Year

Month

18. Mother's Name (First, Middle, Maiden Surname)

Jeannette Weitzman

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13 Dufief Court Gaithersburg, MD 20878

Director Pages 1 and 2 should be filed within 72 hours after death with the Maryland Heath and Mental Hygiene. em 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Expaniner must be notified at Maryland 21215-0036 If item 27 altimore, ₽ Department of Important: If it any injury or o **Physician** /Medical Examiner be executed attending physician and for use as the burial-tran 68760. cate has been signed by the page 2 should be detached Ö Δ Records, certificate has Physician: The Vital director, After this funeral Division death. within 24 hours after death

To the Funeral Director:
completely filled in by the f To the

**Physician** 

/Medical

10a. State

15. Decedent's Education (Specify only highest grade completed)

College (1-4or 5+)

Elementary/Secondary (0-12)

17. Father's Name (First, Middle, Last)

19a. Informant's Name/Relationship (Type. Print)

Andrew J. Katz - Son

Babak Salehi Pirouz,

0

2008

31. Date filed (Month, Day, Year)

OCT

MD

39. Registrar's Signature

Abraham Kolodne

12

20a. Method of Disposition

MD

Director

Funeral

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Completed

Be

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Examine

**Funeral** 

1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Parklawn Menorah Gdns, 10/12/08 Rockville, Maryland 21. Signature of Funeral Service Licenses Danzansky-Goldberg Memorial Chapels, Inc. 1170 Rockville Pike Rockville, MD 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Anoxic Encephalopathy disease or condition resulting in death) Due to (or as a consequence of) Status Post Cardiopulmonary Arrest Sequentially list conditions, if any, reading to infiltediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine Malignant Arrythmia resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 反 Unknown Completed 24a. Was an 1 □ Yes 2 😾 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 🙀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D66264 October 9, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

219 South Washington Street Easton, MD 20017

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			for State Registrar		State of M	iai yiaiiu		artment of i rtificate of	nealth and N <i>Death</i>		giene Reg. No. 2	008	33998
Physician /Medical Examiner			1. Decedent's Name (First, In-Ja L	Middle, L Be	ast)			2. Date of Dea		Year	3. Time of Death 6:41p M		
			4a. Facility Name (If not institution, give street and number)  4b. City, Tov						r Location of Death	1	4c. Count	y of Death	
	Funeral		Casey Ho 5. Social Security Number 579-15-868	6.	Months Dave House			If Under 24 Hrs.	8. Date of Birtl (Mgnth, Day 1 2 / 0 2 /		9. Birthp Coup	ace (State or Foreign	
	Director		579-15-8689 1 M 2 F 63 Yrs. Months Days Hours Min. 12/02/1944 S. Korea									orea	
	arylan show	_	10a. State 10b. County 10c. City, Town or Location								1	Od. Inside City Limits	
	he Ma	ecto	MD Mo	ntgo	mery	Be	thes						1 □Yes 2 🔀No
	ath with t	<b>Funeral Director</b>	9519 Edgeley Road					10f. Zip Code 208	14		10g. Citizen of U	What Coun	try?
5-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Event must be molified at ONCE.	þ	11. Marital Status 1 ☑Never Married 2 ☐ 3 ☐ Widowed 4 ☐ Div		12. Was Decedent Armed Forces 1  Yes 2 If Yes, Give Year or Dates:	No	1	□Yes 2⊠No	fispanic Origin? (Sp an, Mexican, Puerto Specify:	,	14. Ra Bla Specii	ce - Americ ick, White, e fy: AS	an Indian, etc. sian
15-	n 72 h '*natu	lete	15. Dec (Specify only i	edent's E ighest gi	ducation ade completed)		16a. Deced	lent's Usual Occup kind of work done	eation during most of work d)	ing	16b. Kind of B	susiness/Ind	lustry
2121	within jiene. r than "	Completed	Elementary/Secondary (0-	12)	College (1-4or	5+)	Pr	ofessor	a) ·		Montg	omer	y College
br	e filed al Hyg other	Be	17. Father's Name (First, Mi	ddle, Las					18. Mother's Name	e (First, Middle,			
/lar	Mental   arked of	<b>To</b>	Sang-Up Le	3					Kye-H	yang Le	ee Kim		
, Maryland	1 and 2 shout Health and I tem 27 Is mater trauma		19a. Informant's Name/Rela			tor	19b. Mailin 9507	g Address (Street Montgo	and Number or Run	al Route Numbe	r, City or Town Lhesda	, State, Zip , Md	Code) 20814
Baltimore,	les 1 g		20a. Method of Disposition 1   Burial 2 □ Crema	ion a l	Domoval from State	20b. Plac	e of Dispos	sition (Name of natory or other place	ce) [	Date	20c. Location	- City or To	wn, State
ţ	permit. Pag Department Important: I any Injury o		4 □ Donation 5 □ Oth	er (Spec	fy)		te o	f Heave	n 10/0	7/2008			pring,Md
Bal	permit. Departi Importa any Inji		21. Signature of Funeral Se	vice Lice	melel		<b>P</b> 9	HTLTP****D 241 Col	s RTWALD umbia B	I FUNER	RAL SE lver S	RVIC prin	E,P.A. g,Md 2091
	Physician /Medical Examiner		23a. Part 1. Enter the issease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear railure. List only one cause on each line.  Approximate Interval Betw.									Approximate Interval Between Onset and Death	
		Completed by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	1	b								
68760,	ficate be executed if physician and sthe burial-transit		resulting in death, cast	l	Due to (or as a consequence of):								
O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1								ite of deliver	ry Day Year	
rds, P.	quires that en signed t uld be deta		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 █ No 3 ☐ Probably 4 ☐ Unknown		
Il Records,	i: The law requir icate has been s ; page 2 should I									24a. Was a autops perforr 1 □Yes	ned?	Were autop prior to con death? 1 □ Yes	sy findings available apletion of cause of
Vital	Physician: T r this certificat ral director, pa	Be	25. Was case referred to me examiner?	dical	Hospital:			3 🗆 DOA Othe	26. Place of Death				
of	g Phys er this eral dii	1: To	1 ☐ Yes 2 ☑ No 27. Manner of Death		1 ∐ Inpatie	ent 2 ER	Outpatient  b. Time of	3 DOA 28c. Injur	4 LI Nursing Hol	me 5 Reside			hospice
ion	Attending Ph r death. ector: After thi by the funeral	atior	1 Natural 5 □ Pe	nding estigatio	(Month, Da	y, Year)	Injury	Work	? Yes 2 □ No	zou. Describe no	w anjury occurs	reu	
	after des after des I Director d in by th	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	To the Hospital or Attentwithin 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier 1 X Certifier (Check only one) 2 Med	ifylng Pl ical Exa	nysician: To the best niner: On the basis o and manner st	t examination	dge, death and/or inv	occurred at the tir estigation, in my o	ne, date and place, pinion, death occurr	and due to the c ed at the time, d	ause(s) and mate and place,	anner as sta	ated. the cause(s)
	To the within 2 To the complete	Me	29b. Signature and title of ce	tifier	1 /2			29c. License		2	9d. Date signe	d (Month, D	ay, Year)
	8		/ granos	e h	Inoller	usk.	W)	D00	64615		Oct.4	, 2008	3
			30. Name and address of per Geneviev	son who	completed cause of d blewski I	eath (Item 23	a) (Type, P	muncas	tre Mill	. Rd Ro	ckvill	le,Md	1
	Sta Registr		31. Date filed (Month, Day, ) OCT 1	ear)	327 Registra	ar's Signature	Goo	te					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** C. Latimer Oct. 4:00  $A^{M}$ Mary 4 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8 Cold Spring Court Potomac Montgomery If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🗗 F Yrs. 71 Jan. 1, 1937 Maryland Director 217-30-8815 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy highly or other traumatic event, In Medical Exeminer must be rediffed at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 1<sup>2</sup>E Yes 2 ☐ No Director MdMontgomery Potomac 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20854 Funeral 8 Cold Spring Court U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 🗷 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No þ Specify. 8 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Foreign Service Executive Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ည Godfrey Child Louise Byrd 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Latimer / Husband 8 Cold Spring Court Potomac, Md 20854 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 10/08/2008 |Falls Church, Va. 4 ☐ Donation 5 ☐ Other (Specify) National Crematory 22. Name and Address of Facility Joseph Gawler's Sons, Inc. 21. Signature of Puneral Service Ligansee Will 5130 Wisconsin Ave. N.W. Washington D.C. 20016 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Years Idiopathic Pulmonary Fibrosis /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enler Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) is certificate has been signed by the director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation n 24 hours after death. e Funeral Director: Af bletely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 29a. Certifier 1 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 0 October 6, 2008 D32033 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Peter G. Hamm, M.D. 5530 Wisconsin Ave. Chevy Chase, MD 20815

Registrar

State

31. Date filed (Month, Day, Year) OCT 10



			_ State	aryland / Depa <i>Cer</i>	irtment of H <i>tificate of L</i>			ene g. No. 2   1   1   9	21.000		
			Registrar  1. Decedent's Name (First, Middle, Last)		2. Date of Death 3. Time of Death						
	Physicia		Jessie F. Moon		Month October	8, 2008	8:55 PM				
	/Medic Examin		a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death		4c. County of Death			
			Montgomery Hospice - Case	y House	Rockvi			Montgome	ry		
	Funeral Director	al Director	5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)  86 Yrs.  80 Age (In yrs. last birthday)  1 Months Days Hours Min.  80 Age of Birth (Month, Day, Year)  Feb. 26, 1922 Washi:						lace (State or Foreign htry) ngton, DC		
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Loc	cation			11	0d. Inside City Limits		
d 21215-0036	Maryk		Maryland Montgomery	Gaithers	burg				1 □Yes 2 X No		
	3a or 28a		10e. Street and Number 101 Odenthal Avenue, #910	)	10f. Zip Code 20877		100	g. Citizen of What Coun USA	itry?		
	be filed within 72 hours after death with the Marylan Ital Hyglene. d other than 'natural', or Items 23a or 28a-f show event, the Medical Extrainer mast be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ⑤ Divorced  12. Was Decedent Armed Forces?  1 □ Yes 2 😿 1 f Yes, Give Year or Dates:	No I	Was Decedent of Hi f Yes, specify Cuba I □Yes 2½ No	ispanic Origin? (Spec in, Mexican, Puerto R Specify:	cify Yes or No- lican, etc.)	14. Race - Americ Black, White, 6 Specify: Whi	etc.		
5-0036	2 hou lest E		15. Decedent's Education	16a. Decec	dent's Usual Occupa	ation during most of working	16	6b. Kind of Business/Ind			
2	ithin 7 ne.	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5	i+) life, L	ical Psyc	1)		Psycholog			
2	lled w Hygier ther th		17. Father's Name (First, Middle, Last)	CIII	Ical Psyc	18. Mother's Name	(First Middle Ma		У		
and	ed stal	o Be	Walter Preston Fowler			Mary Eli	•				
re, M	ges 1 and 2 should be filed w nt of Health and Mental Hygie If item 27 is marked other t or other traumatic event, III	To	19a. Informant's Name/Relationship (Type. Print)  Michael P. Fowler/ Nephe	1		and Number or Rural		City or Town, State, Zip	Code)		
	Pages 1 and 2 nent of Health int: If item 27 i iry or other tra		20a. Method of Disposition  1 □ XBurial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	20b. Place of Disposementery, crem Rock Creek		October	- 14	Oc. Location - City or To			
Balti	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Licensee	F	name and Address rancis Ja	ss of Facility Collins	Funeral	Home, Inc. lver Spring	. MD 20901		
ш			23a. Part 1. Enter the disease, or complications that caused shock, or heart fallure. List only one cause on each li						Approximate Interval Between		
	Physician		Immediate Cause (Final disease or condition Cerebrovascular Accident								
Name	/Medical Examiner			a consequence of):			*				
		e		Fibrillati	on						
6	cuted id ansit	Examiner	reaching to immediate cause. Enter Underlying Cause (Disease or injury that initiated events								
88760, ∢	cate be executed physician and the burial-transit	al Exa		a consequence of):							
687	ifficate g phys	edical	d								
O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 DNo 9 □ Unknown  23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death 3	Ectopic pregnanc Other (specify)	у		23d. Date of delive Month	ery Day Year		
٠ <u>.</u>	res that t signed by be detac	by Ph	Part II. Other significant conditions contributing to death b	ut not resulting in the ur	nderlying cause give	en in Part I.	23e. Did toba	acco use contribute to the	he cause of death?		
g	w requires been sig should be						1 □ Yes	3 2 No 3 Prot	oably 4 🙀 Unknown		
Reco	: The law re icate has be ; page 2 sho	Be Completed					24a. Was an autopsy perform	prior to co ed? death?	ppsy findings available mpletion of cause of		
/ita	ician: Th certificate ector, pag		25. Was case referred to medical examiner?		100	26. Place of Death	(Check only one	)			
ō	Physical direction	<u>년</u>	1 ☐ Yes 2 ₹ No Hospital: 1 ☐ Inpation  27. Manner of Death 28a. Date of Inju	ent 2 ER/Outpatien		4 LI Nursing Hon	ne 5 Resider	nce 6 MOther (Special	(v) Hospice		
Division of Vital Records, e Hospital or Attending Physician: The law requires the	ding h. After funer	tion:	1 Natural 5 □ Pending (Month, Da	winjury occurred							
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director,	Certification: To	3 Suicide 6 Could not be 28e. Place of Inj	ury - At home, farm, stre c. <i>(Specify)</i>		Yes 2□No 2	8f. Location (Stre City or Town,	eet and Number or Rura State)	al Route Number,		
	ne Hospita n 24 hours ne Funera pletely fille	Medical C	29a. Certifier  (Check only one)  1 Certifying Physician: To the best-of, my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	To the within To the complex c	Ň	29b. Signature and title of certifier		29c. Licens D0 0 64			d. Date signed (Month,			
	0		Jones Wrotte	-an		±013		ctober 9, 2	.000		
	V		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Genevieve Wroblewski, MD, 6001 Muncaster Mill Rd., Rockville, MD 20855								
	Sta Registr			ar's Signature	E)						

Registrar DHMH 17 Rev 1/2001